EXPLORING HOW INTERNAL SAVING AND LENDING (ISAL) SERVICES ASSIST HOUSEHOLDS AFFECTED BY HIV AND AIDS TO SUSTAIN LIVELIHOODS: A CASE OF HOUSEHOLDS IN A RURAL AREA OF ZIMBABWE

by

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submitted in accordance with the requirements for
the degree of

MASTER OF ARTS

In the subject
SOCIOLOGY (SOCIAL BEHAVIOUR STUDIES IN HIV AND AIDS)

at the
UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: Leon Roets

15 December 2019

DECLARATION

I declare that EXPLORING HOW INTERNAL SAVING AND LENDING (ISAL) SERVICES ASSIST HOUSEHOLDS AFFECTED BY HIV AND AIDS TO SUSTAIN LIVELIHOODS: A CASE OF HOUSEHOLDS IN A RURAL AREA OF ZIMBABWE is my own work and that all the sources that I used and quoted have been indicated and acknowledged by means of complete references

15th December 2019

SIGNATURE

DATE

ABSTRACT

The study was an exploration of how internal savings and lending (ISAL) influenced the way in which persons affected by HIV and AIDS earned and spent income. The researcher engaged with the life stories of participants belonging to HIV and AIDS support groups that practised ISAL in rural Bikita district in Zimbabwe. The negative changes brought about by HIV and AIDS were found to influence the way participants generated and spent their income. The initial illness of family members reduced the participation in productive activities of the ill and family members providing care. Compounding effects included reduced attention to and increasing abandonment of productive activities, reduction in the scale of production, the use of inappropriate inputs, forced disposal of assets, increased household debts, reliance on social networks, and dependence on begging and piecework for income. The low productivity from activities meant that households generated less produce and income. This triggered changes in the prioritisation of spending, with healthcare and associated transportation needs superseding all, followed by spending on food. Expenses that were not prioritised during the period of illness included the purchase of improved agricultural inputs, spending on education and clothing and, in some cases, food purchases. In the findings, ISAL is associated with restoring past and starting up new productive and income-generating activities. Regular access to loans allowed storytellers to invest in activities that improved the levels and frequency of income that they earned. Loans were used to directly cover daily family needs, reducing reliance on risky coping mechanisms. Lump sum payments and bulk grocery purchases helped storytellers to invest and manage their cashflow. Overall, households that practised ISAL improved and increased their incomes and ability to spend on healthcare and satisfy other daily needs to levels similar to and better than those experienced before they had to cope with the effects of HIV and AIDS. Recommendations from the study include enabling persons testing HIV positive to access social protection, adapted agriculture technologies and financial education tailored to those affected by HIV and AIDS. Areas for potential further research include a quantitative and qualitative analysis of income and expenditure changes for persons affected by HIV and AIDS and the effects on children of dropping out and being re-enrolled at school.

Keywords; Savings and internal lending, livelihoods, household income, HIV and AIDS, rural community

ACKNOWLEDGMENTS

The successful completion of this dissertation was made possible by tremendous support provided by the management and staff from Batanai HIV and AIDS Service Organisation (BHASO), from the initial introductory meetings, telephone calls and email exchanges on approval and logistics for the study, introductions and directions during community meetings.

The dissertation is about the personal experiences of HIV and AIDS support group members who spared their time from other commitments to share their life experiences with me. I acknowledge that, asking each one of them to share their experience was asking a reliving of the past, that had the possibility of causing trauma from the sensitive and painful moments. I remain sincerely grateful to each one of them, for those precious moments and sacrifices.

While undertaking this study my family was patient and encouraging, which helped me to maintain the needed focus.

I thank my supervisors Leon Roets, for being always available to provide feedback and support that led to the completion of this work.

CONTENTS

LIST OF FIGURES

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
BHASO	Batanai HIV and AIDS Service Organisation
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activities
ISAL	Internal Savings and Lending
NAC	National AIDS Council
SADC	Southern African Development Community
UNAIDS	The Joint United Nations Programme on HIV/AIDS

CHAPTER 1: SITUATING THE RESEARCH PROBLEM

1.1. INTRODUCTION

This first chapter introduces the study. The study focused on understanding how Internal Savings and Lending (ISAL) sustainably changed how persons affected by HIV and AIDS generated and spent their income on daily needs. An overview is given on the HIV and AIDS prevalence in the study area, the response interventions implemented in the country in general, as well as those implemented by Batanai HIV and AIDS Service Organisation (BHASO). Also outlined in this chapter are the research problem, the purpose and objectives of the study, the research questions, methodology, the limitations and definitions of key concepts. The chapter ends with a conclusion.

1.2. BACKGROUND TO THE STUDY

The study was undertaken in Zimbabwe, a country has an estimated 13,151,850 people, the majority (52%) of whom are women (Zimbabwe National Statistical Agency 2019:6). The study was undertaken at three rural sites in Bikita District, see Figure 1. The research participants were members of BHASO supported HIV and AIDS and ISAL interventions.

This study was informed by the effects of HIV and AIDS on the ability of households to engage in productive activities. The effects, which are discussed in Chapter 2, include how HIV and AIDS changes the availability of household labour involved in economic activities which in turn reduces the income generated. When the income is reduced this constrains the capability of households to pay for their daily needs forcing them to change their spending priorities (Ansell, Hajdu, van Blerk & Robson 2016; Fauk, Mwakinyali, Putra & Mwanri 2017; Poudel, Newlands & Simkhada 2015; Tran, Duong, Nguyen, Hwang, Nguyen, Nguyen, Nong, Vu & Ohinmaa 2013). The research participants narrated their life experience when they were affected by HIV and AIDS and participated in ISAL and how both changed their earning and spending of income.

Figure 1: Districts map of Zimbabwe

Source: https://commons.wikimedia.org/wiki/Atlas_of_Zimbabwe#/media/File:Zimbabwe.geohive.gif

1.3. HIV AND AIDS IN ZIMBABWE

In 2016, Zimbabwe had an estimated 1.3 million people living with HIV and 40,000 new infections. In Southern Africa, it is estimated that there was a 50% reduction in HIV prevalence between the period 1997 to 2013, from 26.5% to 14.3% respectively (Government of Zimbabwe, 2015:20). Reductions were also experienced with new infections among adults (50%), children born from HIV positive mothers (75%) and HIV related deaths (60%). The positive changes have been experienced following the implementation of initiatives by the Government of Zimbabwe and the civil society sector that include Social and Behaviour Change Communication, elimination of Mother to Child Transmission, Voluntary Medical Male Circumcision, Condom Programming, HIV Treatment as Prevention, integrated service delivery systems and treatment, care and support. These initiatives were also priorities in the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015-2018. In the plan, the government acknowledges poverty as a potential constraint in utilising services, as affected households must pay user fees, laboratory and X-ray fees, as well as transportation costs (Government of Zimbabwe, 2015:45). Though the plan highlights these issues as priorities, there is no preciseness articulated on the required economic approaches in the output results and core strategies. Local and international organisations have implemented economic strengthening initiatives to address some of the challenges. Examples include the CARE Zimbabwe implemented Supporting the Basic Income and Needs of HIV/AIDS Affected

Households and Individuals project, whose purpose was to reduce the economic vulnerability of affected targeted groups that included orphans, youth, widows, caregivers, sex workers and people living with HIV (Ajain, 2004). The Support to Replicable Innovative, Village/community Efforts project implemented by Catholic Relief Services had similar economic strengthening objectives for different groups affected by HIV and AIDS (Zheke, 2010).

1.4. HIV AND AIDS AND ECONOMIC ACTIVITIES IN BIKITA DISTRICT

The Zimbabwe National Statistics Agency (2012:138) shows that Bikita had a total population of 162,356 of which 88,553 were women and 73,803 were men. Bikita's population density was 34.64 persons per square kilometre (Kassie, Erenstein, Mwangi, LaRovere, Setimela & Langyintuo 2012:8). UNAIDS (2014:11) estimates are that Bikita had 12% HIV prevalence among the 15 to 49 years old age group. In the same age range, 9,000 people lived with HIV and for those 15 years and above 11,000 people were living with the virus.

A study of households in Bikita by Mushore, Muzenda-Mudavanhu, and Makovere (2013:104) found most households growing maize the staple crop, despite its susceptibility to drought and that most are grown using seasonal rains. Other crops grown in the district include rapoko, sorghum, millet, groundnuts, beans and sweet potato. Homestead and communally owned gardens were used to produce vegetables for consumption and surplus sold on local markets. Households also own livestock such as cattle, goats, donkeys and chicken for own consumption or use and in some cases as savings for predictable or unpredictable needs. According to Gukurume (2013:95) and Mushore et al., (2013:104), in addition to crop, vegetable and animal production households in the district participate in other livelihood strategies that include piecework jobs, the sale of fruits, petty trading, self-employment and paid jobs.

1.5. THE RESEARCH PROBLEM

HIV and AIDS can affect how households generate and spend income on daily expenses. It is worth noting here, scholars have written about two direct economic impacts of HIV and AIDS on households (Wafula, Kaseje, Ochieng & Were 2013:152). First, where HIV leads to the sickness of family members this decreases the economic productivity and income-earning by affected households. Household members infected by HIV fall sick and reduce their participation in productive activities, including wage employment and self-employment. Second, other household members who are not sick provide care to the sick, which may also

lead to them reducing their participation in economic activities. The reduced participation in economic activities by sick and caregiving members leads to households earning a lower income than before they experienced HIV and AIDS. The reduced household income may lead to the second economic impact of HIV and AIDS on affected households- the households may not afford to pay for and provide for the daily needs of their families such as food, healthcare and education expenses. The consequences on affected households include being food insecure, at risk of malnutrition and continuous ill-health. When households participate in ISAL, they access regular financial resources, loans and savings that they can use to participate in economic activities and generate income. ISAL may therefore potentially reverse the negative direct impact of HIV and AIDS on households. This study investigated whether HIV and AIDS had economic effects on households and how participating in ISAL by the households changed their ability to generate and spend income on daily needs, as articulated by Wafula et al., (2013).

1.6. THE PURPOSE OF THE STUDY

The purpose of the study was to establish, the nature of changes caused by HIV and AIDS and ISAL on how persons affected by HIV and AIDS generated and spent income on daily needs in the rural Bikita District of Zimbabwe.

1.7. OBJECTIVES OF THE STUDY

The purpose of the study was achieved by focusing on three objectives which are as follows:

- To explore how HIV and AIDS changed the way households earned and spent income on daily needs.
- To explore how financial services accessed from participating in ISAL changed the way persons affected by HIV and AIDS generated and spent income on daily needs.

1.8. THE RESEARCH QUESTIONS

The two research questions and related sub-questions underpinning the study are as follows:

- In what way does HIV and AIDS change the way persons affected by HIV and AIDS generate and spend income?
    - How does HIV and AIDS change the way households generate income?
    - What way does HIV and AIDS change the way households spend income?
- How does participation in ISAL by persons affected by HIV and AIDS change their generation and spending of income?

- How does access to ISAL financial services change the way households generate income?
- How does access to ISAL financial services change the way households spend income?

1.9. DEFINITION OF KEY TERMS

ISAL methodology: Is a practice where individuals organise into groups that regularly and collectively save money into a common fund. The fund is used to provide members with loans that are repaid on agreed terms. The saving, repaying and borrowing continue over time until the accumulated savings are shared-out among members and they start new saving and lending cycles. As Beaman, Karlan & Thuysbaert (2014:20) state, most communities have some form of informal saving mechanism. These are variedly named, from *asusus* in West Africa, *stokvels* in South Africa, *maraundi* in Zimbabwe and *chamas* in Kenya. The ISAL methodology improves on informal savings practice common in most communities. The improvements include structured management, recording systems, group formation and planning.

ISAL cycle: The number of weeks or months that it takes for an ISAL group to start regularly saving, providing loans and receiving loan repayments up to the time they share-out all or part of the savings accumulated in their fund. This is consistent with the description that Cassidy & Fafchamps (2015:10) and Ksoll, Bie Lilleør, Lønborg & Rasmussen (2016:72) give on village savings and loan associations that use the same methodology as ISAL.

Persons affected by HIV and AIDS: Individuals living with HIV, and any of their family members who provide care and support, or whose situation and needs may be affected by living in a family where there is a member with an HIV-positive status (UNAIDS, 2015:10)

Resilience: the ability of households to anticipate, withstand and recover from the effects of shocks and stresses and still meet their livelihood needs to acceptable levels (Turnbull, Charlotte & Hilleboe, 2013:160).

Rural community: this is a geographical residential setting where resident families depend mostly on agricultural production. In Zimbabwe, such areas fall under the jurisdiction of a rural district council.

Sharing-out: This is a process, where an ISAL group calculates all the accumulated savings in their fund and they pay the money out to the members on an agreed pattern that may be in proportion to what each saved or equal amounts (Oxfam America, 2013).

Socio-economic impact: the positive or negative changes that individuals or groups experience and can attribute to the implementation of development projects (Hempel & Fiala, 2012:72).

Sustainable livelihoods: A livelihood is sustainable when a household uses its assets and capacities to continue with their productive activities and to meet normal needs and recover when they experience the effects of shocks and stresses and without negatively affecting the natural resource base, according to Duffy (2015:404), citing DFID and Sati and Vangchhia (2017:1) citing Scoones.

1.10. BRIEF OVERVIEW OF THE RESEARCH PROCESS

A systematic process detailed in Chapter 3 was followed in planning and executing the study. The initial step was engaging BHASO management to obtain their permission to conduct the study with communities where they had implemented HIV and AIDS and ISAL programmes. The district of the study was then purposively selected based on the time that both HIV and AIDS and ISAL programmes were implemented. Consideration was whether the programmes were implemented for periods that were long enough to generate the depth of experience for the study. BHASO field staff in Bikita was engaged by the researcher on the study and the profile of the required purposively selected sample. The staff was requested to assist in getting access to the study location and organising meetings at the community level.

Interviews with participants were conducted over two days. At two sites, interviews were conducted in closed-door rooms with each interviewee. At one site, a secluded open space away from interruption was used. Each interview started with the introduction of the researcher and the participant, the study purpose, verbal explanation and request of the informed consent and the interviewing. Each storytelling started with a generative question that allowed individuals to share their relevant experiences. The researcher interviewed all nine individuals using the local vernacular Shona language and they all responded using the same medium. The language is spoken, written and understood by the researcher and the participants, which

made managing the process easy. Transcriptions were immediately made in English. The participants were asked open-ended generative questions to share their stories. At some point, probing questions were used to clarify and better understand the issues. Whenever there were interruptions during the interview process the researcher provided a summary of what had been shared before the storytelling resumed. At the end of each interview, the researcher summarised the understanding of each story and allowed participants to correct and volunteer additional information.

As will be shown in Chapter 3, the analysis of findings started in the field with each interview conducted. During each interview, themes emerging were immediately noted. At the end of each day, the field written notes were read through and reviewed to further identify themes, corroboration of experience across stories, diversity of experience and perspectives and specificity of details such as the when and where of experience. In compiling the study report, the anonymity of participants was maintained by the use of pseudonyms for their names and those of their support groups and savings groups. The written notes from the interviews were stored in a lockable cabinet at the researcher's residence.

1.11. CONCLUSION

The chapter presented an overview of the HIV related prevalence in the geographical context of the study and some of HIV response interventions. Also presented are the effects of HIV and AIDS household participation in productive and income generation activities and spending. The purpose and objectives of the study, as well as the definitions of key concepts, are also presented. The research methodology for the study is also presented.

Chapter 2 presents the literature review on HIV and AIDS in the global and study context, the household level economic burden of HIV and AIDS, the economic strengthening approaches for persons affected by HIV and AIDS, including those implemented by BHASO and the theories applicable to the study.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

This chapter presents the global, regional, country and district trends on key HIV and AIDS statistics. It also outlines the economic burden on households associated with HIV, the economic strengthening interventions for persons affected by HIV and AIDS, BHASO's HIV and AIDS and ISAL interventions and the theoretical framework related to the study. The chapter ends with the conclusion.

2.2. HIV AND AIDS GLOBAL AND REGIONAL TRENDS

In 2017, it is reported that the world had 36.9 million persons living with HIV and 940,000 people who died because of AIDS-related sickness leading to a cumulative 35.4 million deaths since the onset of the epidemic (UNAIDS, 2018:1). Globally, there was an observed trend in the reduction of Aids-related deaths, and positive trends in Antiretroviral therapy (ART) coverage and new infections. According to UNAIDS (2018:2), between 2004 and 2017, there was a decline of about 51% in HIV-related deaths, that could reflect both the positive impact of increasing ART coverage, positive living behaviours and support to those living with the virus. There is a noted increase in the coverage of ART, with UNAIDS (2018:1) reporting that 2.3 million more people accessed ART in 2017, as compared to 2016. Increased HIV and AIDS awareness, behaviour change and access and use of transmission prevention methods can be associated with the decline in new infections. The global new infections for adults have declined by 16% from 1.8 million in 2010 to 1.6 million in 2017. According to UNAIDS, in 2017 an estimated 25% of the global population lived with HIV, but did not know their status, which is a significantly high representation and challenge to the global HIV response.

The eastern and southern Africa sub-regions have a substantial share, 44%, of global new HIV infections, according to UNAIDS. In 2017, the sub-regions had 19.6 million people living with HIV and showed positive trends in decline in reported new HIV infections and AIDS-related deaths (UNAIDS, 2018:4). In 2016, there were 77 000 new HIV infections among children, a 56% decline from the 2010 figures. Overall, a 29% decline in new HIV infections was experienced between 2010 and 2016 (UNAIDS, 2017:2). In 2016, deaths related to HIV were 420 000, a decline of 42% from 2010 figures (UNAIDS, 2017:2). UNAIDS estimates indicate that 12.9 million people living with the virus had access to ART in 2016 (UNAIDS 2018:4).

2.3. HIV AND AIDS TRENDS IN ZIMBABWE

Zimbabwe recorded its first AIDS case in 1985. The first policy response by the Government of Zimbabwe was in 1999 when the National AIDS Policy came into effect**.** The translation of the country's AIDS policy into deliverables was guided by an initial Zimbabwe National HIV and AIDS Strategic Framework (2000-2004) followed-on by other frameworks. To complement the implementation of the frameworks, the country developed the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) which outlined priorities that included the prevention of new infections, access, and utilisation of treatment and care services, support for those infected and affected by HIV and AIDS, as well as management and coordination of responses.

In 1999, the National AIDS Council of Zimbabwe Act was enacted, leading to the establishment of the National AIDS Council (NAC), whose operations started in 2000. NAC is a multi-sector agency with a mandate to provide leadership in mobilising the efforts of stakeholders in responding to the epidemic. NAC's decentralised structure comprises Provincial, District, Ward and Village AIDS Action committees, as mechanisms for effective engagement of persons affected by HIV and AIDS. This study was undertaken at the village level where Village AIDS Action Committees are responsible for, among others, identifying projects, developing proposals and budgets, setting targets, selecting beneficiaries, reporting and overseeing the implementation of activities.

In 1999, the Government of Zimbabwe introduced an AIDS levy for the formally employed workforce, under an Act of Parliament. The 3% levy is collected from the income tax of individuals and profits of business entities. The levy contributes significant resources towards the HIV and AIDS response, with Bhata, Kilmarx, Dube, Manenji, Dube and Magure (2016:5) stating that in 2014, the levy raised $38.6 million. An assessment by Bhata et al., (2016) showed that half of the funds had been used for the procurement of ARVs, with the remaining directed to other priority areas such as prevention.

Since recording the first AIDS case, Zimbabwe experienced a steep increase in adult prevalence reaching a peak of 27.7% in 1997. After this, the country had the second phase of gradual decline in prevalence reaching 16.7% in 2014, according to UNAIDS (2015) and Zimbabwe Government (2014:6). Duri, Stray-Pedersenand Muller (2013:18) point out that the decline was marginally different between men and women, with the former recording 15% against 16% for the latter between 2005 and 2010 Demographic Health Surveys. The decline

is attributed to the effectiveness of interventions that include behaviour change, condom use, reduction in concurrent and other multiple sexual partnerships, prevention of Mother to Child Transmission, treatment care and support, male circumcision and families experiencing first hand HIV and AIDS-related sickness and deaths, as affirmed by Duri et al., (2013:18); and Gregson, Nyamukapa, Schumacher, Magutshwa-Zitha, Skovdal, Yekeye, Sherr and Campbell (2013:88). Zimbabwe is recorded as having the sixth-highest adult HIV prevalence, at 13%, in sub-Saharan Africa. UNAIDS (2018) reports that in 2017, the country had an estimated 1.3 million people living with HIV and 41,000 new infections. Of the people living with HIV, 57% were women, indicating the disproportionate effect the epidemic has by gender. This is consistent with the Government of Zimbabwe reports that in 2016, women within the 15-24 years age group recorded 2.78 times higher prevalence than men (Government of Zimbabwe 2017:5). In 2017, the country recorded 22,000 AIDS-related deaths and coverage of ART was 84% for adults (UNAIDS 2018).

In the analysis by the Government of Zimbabwe (2013:1), the country has locations that are at high risk of the spread of HIV and these include border towns, mining areas, growth points, and resettlement farms and urban areas. Of note are growth points that are centres of business activity and serve largely rural catchment areas. Nyika is the growth point and main centre for business activity and administrative services for Bikita District. The study was undertaken at three sites located between 10 to 40 kilometres from Nyika Growth Point. One of the sites, Mungezi, is a small-scale commercial farm settlement and the other two, Chidhumira and Chikuku, are rural villages.

In 2007, Zimbabwe had about 56% of its population living in extreme absolute poverty, less than US$1 per day. In 2012, 72% of the country's population lived below the national poverty line, as reported by Pascoe, Langhaug, Mavhu, Hargreaves, Jaffar, Hayes and Cowan (2015:2). These statistics are of significance, given the synergistic relationship between HIV and AIDS and poverty.

2.4. ECONOMIC BURDEN OF HIV RELATED SICKNESS ON HOUSEHOLDS

Scholars like Ansell et al., (2016:28), Fauk et al., (2017:5), Poudel et al., (2015:507) and Tran, Duong, Nguyen, Hwang, Nguyen, Nguyen, Nong, Vu & Ohinmaa (2013:215) highlight the economic effects of HIV and AIDS when it leads to sickness of household members. According to the scholars, when persons affected by HIV and AIDS have sickness in the households, this

changes productivity, income generation, the flow of remittances, ownership of assets and allocation of productive resources. Lipton (2012) argues that these effects of HIV and AIDS are significant in contexts where the major economic activities are dependent on human labour. This is the case in Southern Africa where, according to Lipton (2012:4), agriculture provides work to 70% of the economically active population. This dependence on human labour, as argued by the scholar, may mean that a reduction in the number of the active population, because of sickness, may lead to a large part of the region's population not participating in productive activities. This, in turn, may reduce the income they can generate and their ability to pay for their daily needs. Alam and Mahal (2014:9) point to a case in South Africa, where persons affected by HIV and AIDS spend 35% to 50% lower than those not affected, because of pressures associated with reduced income earning.

2.4.1. Reduction of household productive labour

Alam and Mahal (2014) and Wafula, Kaseje, Ochieng and Were (2013) argue that where sickness affects adult household members, this reduces the number of productive labour that can regularly participate in economic activities such as employment and self-employment. The change would result in loss of employment income and reduced household productivity, as well as sales for those who are self-employed. A study from Nigeria showed the effects of HIV related sickness on the availability of labour in productive activities. Alam and Mahal (2014:9) found in a Nigerian study, sickness of persons living with HIV reducing work participation and contributing about 40% income loss per year, as compared to control households. In Zimbabwe, the agricultural sector lost 23% of its workforce due to HIV-related sickness and deaths, according to Duri et al., (2013:20), quoting FAO. The evidence is relevant to the context where this study was undertaken. According to Mawere and Awuah-Nyamekye (2015:12-13), households in Bikita draw much of their labour from family and the local community. Bikita District had most households engaged in labour-intensive agriculture production, which is not reliable because of varying factors that include erratic rainfall and access to inputs, according to Mapuranga, Chiwanza, Musingafi and Pombi (2015:2). According to Mapuva and Madyauta (2016:1), other factors contributing to food insecurity in the district include, lack of access to agricultural inputs and poor farming practices. In 2012, according to Zimstats (2012), 82% of the employed persons in Bikita was in agricultural occupations. The dominance of human labour in agriculture is a pertinent characteristic. It points to the likely vulnerability of household livelihoods when HIV affects labour availability either due to sickness, loss of lives, and diversion of labour to care and support. Households

without sufficient labour would be at risk of having their productive activities, their income, and food security negatively affected. In the district, as Wafula et al., (2013:152) note, persons affected by HIV and AIDS that produce crops often experience a decline in marketed maize output and reduction in income levels.

2.4.2. Reduction of employment income

Other scholars have shown that persons affected by HIV and AIDS experience up to a 67% decline in mean income because of the effects of the sickness. In a case from Tanzania, according to Alam and Mahal (2014:6), there was a noted 66% - 75% less likelihood of men aged 20–50 years participating in wage employment in the 6 months leading to the HIV-related death. In Vietnam and Cambodia, persons affected by HIV and AIDS earned lower incomes, as compared to those not affected. While experiencing high medical costs, persons affected by HIV and AIDS in Vietnam had a lower mean per capita income of US$99 per month, against the 2011 national figure of US$108(Tran et al.,2013). In Cambodia, Nomoto, Saint, Poudel, Yasuoka and Jimba (2013:5) observed that the median income of persons affected by HIV and AIDS was 41% lower than that of unaffected households. The loss of employment income may reduce remittances that employed family members transfer to their families, in cases where they reside in different locations. The possibility of reduced remittances may influence the ability of the receiving household members to meet the expenses for some of their needs.

2.4.3. Reduction of productivity and income from self-employment activities

Some scholars argue that sickness affects the regular operation of economic activities by persons affected by HIV, with effects on the levels of productivity (Otieno, Were, Kabiru & Waza, 2017). The reduction in production affects the availability of goods that households exchange for income or consume. The activities may include the production and sale of crops, livestock, various trade, service and manufacturing activities in any sector of the economy; both agricultural and non-agricultural sectors. Following findings from a study in Kenya, Otieno et al., (2017:46) argue that a decline in the availability of labour through sickness and death led to a decrease in household agricultural production and food insecurity. Comparison is made on the levels of productivity before and after sickness, and the changes observed were used in reaching the conclusion. Household harvests were not adequate to get surplus to sell and reserve enough to meet the consumption needs of their families.

2.4.4. Diversion of productive labour to care and support

Alam and Mahal (2014:9) refer to how caregiving responsibilities reduce work participation for HIV and AIDS affected households in Nigeria. Sickness may force households to divert available productive family labour from economic activities to care and support for the sick. The diversion may have consequences that include the inability to earn income and drop-out from school, in the case of school-age children. This affects both the current and future ability of households to earn income and meet their daily expenses.

2.4.5. Changing household spending patterns and healthcare expenses

A study by Chikobvu, Chiputwa, Langyintuo, LaRovere and Mwangi (2010:18) showed that the expenditure of rural households in Bikita District was dominated by social or consumption needs. The expenses may not generate income and where some may do so, such as education, this would not be guaranteed and would not be immediate. Most (71.1%) spending by households was on education, 17.6% on food and 4.4% on health care. In contexts as the studied location, where households experience HIV related sickness, these findings may indicate the risk of an increase in health-related and unproductive expenses. Alam and Mahal (2014: 5) reviewed the expenditure of households affected by HIV, tuberculosis and malaria, and argued that poor households spend more share of their income on healthcare than richer households. Similarly, Wafula et al., (2013:152) found persons affected by HIV and AIDS spending twice more on healthcare than other household expenses. Tran et al., (2013:215-6) found that persons affected by HIV and AIDS had mean total spending on healthcare services of $16 per month, while that of the general population was at $10. Also, scholars argue that persons affected by HIV and AIDS also spend on services that enable them to access health care facilities. Nomoto et al., (2013:5) found persons affected by HIV and AIDS spending 40% on transportation, as compared to households that were not affected.

The increasing pressure from health care and allied expenses may change how households spend on other household needs. In 13 out of the 20 cases analysed by Alam and Mahal (2014:10), they found expenditure on non-medical needs declined for persons affected by HIV and AIDS. The decline ranged from 15% to 35% and the significance of the impact was noted where the household head was the one affected.

2.4.6. Challenges with access to financial services

Persons affected by HIV and AIDS may use financial services such as loans and savings to meet their pressing needs and support the restoration of economic activities. However, there are divergent views among scholars, on whether these services are effective for persons affected by HIV and AIDS. Some of the views are drawn from savings and loan products offered by formal financial services providers, and these remain relevant for community-managed financial services models, such as ISAL. The views are expressed by different scholars such as Peprah and Buonbah (2014), Tsai, Witte, Aira, Altantsetseg and Riedel (2014), Wagner, Rana, Linnemayr, Balya and Buzaalirwa (2012). The optimistic views are that when households have opportunities to access loans, they may invest in productive activities and increase the levels of income earned and at their disposal to pay for daily needs. Sarka and Haider (2014:110) argue that when households use loans to improve their income, they spend on health-related needs, including improving environmental conditions, curative sickness, prevention, food security and access to healthcare. Investments in environmental conditions include water and sanitation facilities that have positive health effects. This was found in a study of savings and loan groups in Tanzania (Kessy, Stray-Pedersen, Msuya, Mushi & Grete,2017:39). Also, Hamad and Fernald (2015:1) argue that when households afford to pay for such and other needs, this reduces the stress associated with households living in poverty. Loans may also improve the roles that different household members play on decisions regarding the generation and spending of income. Kato and Kratzer (2013:34), Kireti and Sakwa (2014.52), Kumar, Hossain and Gope (2012:118) and Modi, Patel and Patel (2014:73) argue that access to financial services increases the role of women in intra-household decision-making, enhancing their empowerment, improving family and child health and welfare through the ability to pay for school fees, food, health and other needs. In contexts such as rural Zimbabwe, where most women are not formally employed, their participation in economic activities beyond agricultural production and contribution to household income may reduce the vulnerability of their households to the effects of sickness.

Other scholars point to the negative effects of savings and loan products on vulnerable households, including persons affected by HIV and AIDS. The improvements in income, experienced by persons affected by HIV and AIDS, are viewed as not adequate and overwhelmed by healthcare and other expenses. Persons affected by HIV and AIDS, who experience sickness and operate enterprises financed by loans may be forced to operate less

frequently and generate less income. This affects their ability to manage loan repayments and meet their daily expenses. This raises concerns (Wagner et al.,2012: 2) on the appropriateness of microfinance for persons affected by HIV and AIDS. The scholars view microfinance as posing a risk for persons affected by HIV and AIDs being caught-up in vicious cycles of taking new loans to repay other loans. Persons affected by HIV and AIDS may perpetually depend on loans as healthcare expenses become a regular part of their household budgets. These challenges may lead to increased indebtedness and stress for persons affected by HIV and AIDS (Hamad & Fernald, 2015: 2).

Access to financial services is associated with the transaction costs and requirements for collateral security by formal financial services providers. The high costs of accessing and servicing debt are viewed as a challenge for persons affected by HIV and AIDS (Arrivillaga & Salced, 2014:24 citing Bateman) and Bateman and Chang (2010). This is pertinent for rural Bikita District where there is limited penetration of financial services providers. According to Chikobvu et al., (2010:1), one of the reasons cited for not accessing loans was the lack of providers by 59% of the 54% of studied households in Bikita**.** Persons in need of financial services may incur transport costs to access and service financial services from the nearest town which is about 60 kilometres away. These transaction costs may reduce the income earned by households and available for use to meet daily expenses. Collateral required by financial service providers is usually in the form of physical assets. Persons affected by HIV and AIDS may have liquidated some of their physical assets, limiting their ability to meet one requirement to access and benefit from loans. As Chikobvu et al., (2010:1) found in Bikita, 22% of the households cited lack of collateral as the barrier to access credit.

It remains questionable, whether access to loans and savings may change adherence to ART and restore the productive labour of sick household members. A finding from a Colombian study by Arrivillaga, Salcedo, and Mauricio (2014) had mixed results, from participants receiving microfinance, entrepreneurship and adherence to treatment services. Few participants continued operating legal micro-businesses putting to question the sustainability of the positive effects of financial services on the wellbeing of persons affected by HIV and AIDS. Also, persons affected by HIV and AIDS may not be able to restore the assets and savings that they liquidated during sickness. What may be drawn from this is that households affected by HIV and AIDS may be forced to further liquidate the remaining assets to pay-off loans, as the burden of healthcare expenses and loss of productive labour increases. The

households may be more vulnerable and exposed to the impact of HIV and AIDS, and unable to meet daily expenses. Masuku, Kibirige and Singh (2015), Wafula et al., (2013) and Kalinda (2014:58) refers to how HIV related sickness forced households to use available savings for healthcare, funeral and education expenses. ISAL requires members to regularly save, which may not be easy to manage in the face of pressure from consumption needs induced by sickness and poverty (Arrivillaga et al., 2014: 399). This raises questions on the likelihood of ISAL changing how households affected by HIV and AIDS earn and spend income.

2.4.7. Reliance on risky coping mechanisms

When incomes are reduced and not adequate to meet healthcare and other daily expenses, households affected by HIV and AIDS may resort to several coping strategies. As Alam and Mahal (2014:10), Nomoto et al., (2013:5) and Poudel et al., (2015:504) state, some of the strategies that households may use would be uncharacteristic as they may leave them worse-off and more vulnerable to the economic effects of HIV and AIDS. The strategies include begging, increasing the number of income sources, taking loans, selling or pawning assets, taking gifts, relying on support from neighbours and relatives, hiring of labour, reducing food consumption, withdrawing savings, reducing expenditure on education and withdrawing children from school. The economic effects of each of these strategies on households affected by HIV and AIDS raised by Alam and Mahal (2014), Nomoto et al., (2013) and Poudel et al., (2015) are further elaborated below.

Transactional strategies such as begging, hiring labour and selling assets may ultimately lead to negative consequences such as exploitation and loss of self-esteem by households affected by HIV and AIDS. Households may participate in more than one income-earning activity to increase and smoothen the flow of income. When one income source has operational challenges the household cash flow may not be affected as they can rely on the other activities.

Scholars like Sarkar and Haider (2014:113) and Hamad and Fernald (2015:14) highlight how multiple responsibilities may also have negative consequences for households with labour and income constraints. Members participating in multiple activities will stretch themselves by working longer hours and choosing less dignifying opportunities that negatively affect their physical, mental and health well-being. Loans may be the only option households have to meet healthcare and other daily needs. When loans are taken, while at the same time production and income are declining, this may increase the liabilities of households and reduce their ability

to recover. When regular income sources are failing, households may be forced to dispose of any types of assets, including livestock and furniture, in exchange for cash to meet daily needs. Assets may be lost when they are used as collateral security for loans. Some of the assets are used in the production and generation of income and their loss may further negatively affect the ability to earn income. As income levels continue to decline and healthcare expenses increase, persons affected by HIV and AIDS may reduce the frequency and quality of meals. Regular meals maybe missed and certain food types not consumed. Households may introduce cheap and low-quality food substitutes to save the available cash for healthcare. This in turn may affect the nutritional and health status and productivity of members, as well as the exposure of households to diseases with possible subsequent effects of increasing healthcare expenses.

Savings are financial assets that households use to plan for investment and meeting emergencies. Unplanned use of savings, as may happen during sickness, may leave households vulnerable and unable to achieve their financial goals. Educating children build human assets, as the qualifications and skills may be used in the future for households to earn income. This potential may be lost in the event of children being forced to withdraw and drop-out of school because of competing healthcare expenses. Li, Chi, Sherr, Cluver, and Stanton (2015:221) and Sherr, Cluver, Betancourt, Kellerman, Richter and Desmond (2014:253) add other measures to earn income that may be adopted by persons affected by HIV and AIDS, that affect the future economic potential of children. These may include involving children in transactional sex, child labour, early marriages, providing care and support for the sick. Farming households like those in Bikita district, apply additional strategies that may still have negative effects on income generation. The strategies, as highlighted by Wafula et al., (2013), include reducing the diversity of crops grown and the production of cash crops and preference for low labour-intensive farming activities. Households with sickness may reduce the number of crops they grow and the frequency of cropping, as measures to cope with shortages of labour for planting, weeding and harvesting. Cash crops such as cotton and tobacco have a high demand for labour at different production stages, which may not be adequately available in households that have sicknesses. Households may resort to producing crops that demand less labour, such as maize in Zimbabwe, though these usually do not have competitive prices that assure enough income to meet daily needs. Persons affected by HIV and AIDS may cope with a shortage of labour by participating in collective work, a practice found in Zimbabwe. Households take turns to work on each other's field, with the hosting household providing

refreshments. Mawere and Mubaya (2015:12) argue that this practice is used during key agricultural activities such as weeding and harvesting of crops.

Peprah and Buonbah (2014:142) argue that financial services may reduce the risk of HIV, as households engage in productive activities that reduce their reliance on risky means of livelihoods. This may be particularly important where HIV related sickness may force affected households to dispose of their assets, withdraw savings and divert capital from productive activities to meet healthcare expenses. The ability of households affected by sickness or at risk of HIV related sickness to continue participating in economic activities may reduce their vulnerability and resilience to HIV related adversities and have a positive change in other HIV prevention domains. Arrivillaga and Salced (2014:17) refer to a study of 227 female sex workers in Kenya, where 151 continued operating their enterprises after the project. In Uganda, a study by Jennings, Ssewamala and Nabunya (2015) found differences in HIV prevention attitudes between control and treatment groups of orphaned adolescents at baseline and after savings-led economic empowerment interventions. The common services provided to both groups included counselling, school lunch and materials. Services exclusive to the treatment group were mentoring, financial education and matched child savings accounts. At baseline, Jennings et al., (2015: 6) found both groups recording attitudinal scores that were in the same range on the perceived risk of HIV, sexual abstinence or delayed initiation, and consistent condom use. After 24 months of intervention, the treatment group recorded significant attitudinal changes from the baseline; 80.4% to 95.8% after 24 months on the perceived risk of HIV, 78.8% to 91.6% on sexual abstinence or postponement and 73.2% to 93.4% for consistent condom use. Arrivillaga and Salced (2014:16-17) refer to post-intervention studies in India and Kenya, where female sex workers participating in HIV prevention education and microfinance interventions experienced a reduction in income from sex work, low numbers of sexual partners, stopping sex work and an increase in self-reporting on use of condoms with regular partners.

The literature above reviewed highlighted the issues associated with the change that HIV and AIDS cause on the participation of persons affected in productive activities, income levels and spending priorities. The major factor related to HIV and AIDS affecting the economic situation of households is the sickness of family members. When there is sickness, this may reduce the labour available in households to participate in productive activities because of low energy and incapacitation, fewer people involved and time for the activities. The compromised labour has

consequences including reducing the income that households earn, the produce they realise from the activities, increasing healthcare expenses and the inability to meet other daily needs. The literature highlights the contention that exists on whether providing financial services to households facing these challenges can improve their ability to meet daily needs. The optimistic views see loans and savings improving the ability of affected households to generate and spend income. The pessimistic views see loans increasing household indebtedness and the inability to meet expenses and meeting obligations of savings activities being beyond the capacity of persons affected by HIV and AIDS. The study fits within the context of these contentious views by seeking to understand how ISAL could have supported and the changes it caused on how households affected by HIV and AIDS in rural Bikita district generated and spent income on their daily needs.

2.5. ECONOMIC STRENGTHENING INTERVENTIONS FOR PERSONS AFFECTED BY HIV AND AIDS

2.5.1. Economic strengthening interventions in general

Economic strengthening comprises a range of interventions that are meant to reduce the economic vulnerability of households and improving their wellbeing (Ssewamala & Bermudez, 2017:2). Despite the strong link between HIV and AIDS and economic security, initial HIV responses had a major focus on improving access to treatment, care and support services. There were very minimal efforts to strengthen or restore the economic security of affected persons. However, there has been an increasing inclusion of economic strengthening approaches as part of multi-sector HIV responses. The inclusion of economic strengthening approaches recognises that improving income enhances the chances of households to pay and provide for the needs of their families. Economic strengthening approaches that have been implemented include cash and asset transfers, promotion of savings groups, financial education, microenterprise development, microcredit and technical education and vocational training (Ssewamala & Bermudez, 2017). The type and combination of interventions implemented are determined by context and the vulnerability profiles of households.

2.5.2. Economic strengthening interventions in Zimbabwe

In Zimbabwe, economic strengthening approaches have been implemented, dating back to around 2002. Examples include CARE Zimbabwe's Supporting the Income and Basic Needs of HIV/AIDS Affected Households (SIMBA) project that promoted savings groups and

enterprises development services and Catholic Relief Services' (CRS) Support to Replicable, Innovative Village-Community Level Efforts for Vulnerable Children that implemented savings groups and homestead gardens (Jain, 2004; Zheke, 2010:1). Over the years, most of the standard economic strengthening approaches have been implemented in the country by various agencies beyond CARE and CRS. This study particularly focuses on Internal Savings and Lending groups, which is a name for savings groups used by CARE and its partners in Zimbabwe.

2.5.3. Batanai HIV and AIDS Service Organisation programming

Batanai HIV and AIDS Service Organisation (BHASO) was formed in 1992 and registered in 1996 as a private voluntary organisation that supports persons living with HIV to form support groups. Their services broadened to include youths, smallholder farmers, orphans, and other vulnerable children. The organisation operates in Bikita, Gutu, Chivi, Zaka, Mwenezi, Chiredzi, Masvingo Rural and Masvingo Urban districts. The HIV response strategy for BHASO has four broad programming areas; New Life Post Test Support, Positive Development, Gender and Advocacy, and Food Security and Livelihoods. The New Life Post Test Support programme provides free counselling services to persons living with HIV, those on the Prevention of Parent to Child Transmission Programme, workplaces, prisons and patients of the Opportunistic Infections Clinic. The Positive Development programme promotes HIV support groups to mobilise people living with the virus for positive living, engaging in self-help, promoting behaviour change and monitoring the adherence of members to ART. Other activities target OVC households with the awareness of child rights and asset creation. The Children's ART Literacy improves awareness of ART, HIV and AIDS and tuberculosis among children and caregivers. Youths are supported for leadership and engaging in HIV and AIDS issues in their communities. The terminally ill are supported by the Community Home Based Care intervention. The Gender and Advocacy programme builds the capacity of persons living with HIV to engage in human rights issues and influence relevant policy and service delivery issues and processes. The Food Security and Livelihoods programme supports smallholder farmers to adopt improved farming practices and access input and output markets, entrepreneurship development and practicing ISAL.

The study focused on the ISAL component of BHASO's Food Security and Livelihoods programme. Since 2009, BHASO promoted the ISAL methodology with the first operations in Bikita District. ISAL was promoted through existing HIV support groups with the expectation

that all members will be involved. The rationale for BHASO was to encourage self-help among support group members. Savings mobilised by the groups would be used to invest in income-generating activities and improving access to income for use on the wellbeing needs of their families.

2.6. THEORETICAL FRAMEWORKS

Three theoretical perspectives are applied to understand how participation in ISAL could have changed how persons affected by HIV and AIDS generated and spent income on daily needs. These are the collaborative advantage, social capital and economic empowerment theories. Two of the theories explore the relationship between groups and individuals, considering that the ISAL methodology uses a group methodology. The theories help in understanding how individual actions and decisions are influenced by their association with group structures. Baral, Carmen, Logie, Grosso, Wirtz and Beyrer (2013: 2) argue on the role and influence of social and structural factors on individual behaviour. In ISAL savings are supposed to be mobilised through groups and members receiving loans based on decisions made by the groups. Also, groups agree on the collective use of some savings. It is therefore possible that changes caused by ISAL on how persons affected by HIV and AIDS generated and spent income can be better understood through the decisions, actions and influence of groups. Also, the theories may shed light on whether the knowledge gained by persons affected by HIV and AIDS on ISAL is used in taking decisions to improve the economic circumstances of their households. This includes whether loans and lump sums that members access from groups enable them to decide on investing in economic activities and generate sufficient income to pay for daily expenses.

2.6.1. Collaborative advantage theory

The collaborative advantage theory explains how individuals can achieve their objectives by sharing resources, expertise, risk and mutual learning with others (Huxham & Vangen, 2013:3-6). ISAL requires everyone to contribute agreed amounts to a common fund from which they take turns to access loans. The penultimate benefit of this collective financial resource is the sharing-out of lump sums at the end of cycles. ISAL groups charge monthly interest on loans and this is the main contributor to the growth of group funds and the financial benefit that individuals get at the end of cycles. Individuals use lump sums to achieve household objectives such as investing in income-generating activities or meeting survival needs. The achievements from past ISAL cycles may create a sense of shared achievement and are incentives for

continued membership to the groups. Through collective sharing of financial resources, individuals continue to meet their aspirations for income generation and spending.

2.6.2. Social capital theory

Tzanakis (2013: 6), quoting Putman, refers to social capital as features of social organisations, such as norms and trust that are used to facilitate action and cooperation for mutual benefit to members. When ISAL savings are made, trust is central to subsequent processes. In the early stages of an ISAL cycle, available group funds are not sufficient for every member to take a loan, so others must wait for their turn. The few individuals who take loans receive part of their savings and that of other members. The individuals not taking loans trust that the borrowers will repay the loans, that are made up of everyone's money. Individuals not taking loans at a meeting look forward to their turn to get loans in subsequent meetings. Members who had the chance to take loans are expected to reciprocate the patience and trust that non-borrowers showed in past meetings. Reciprocity is one attribute of social capital (Christoforou & Davis,2014: 6).

When members select each other to practice ISAL, they consider pre-existing social ties to form groups. In the case of the study population, the basis for building social cohesion includes being persons affected by HIV and AIDS, the experience of loss, being on ART and membership to a support group. These are used as a basis to realise financial benefits through ISAL processes. Such a connection between social ties and economic benefits is explained by Postelnicu, Hermes and Juarez (2015: 26). They argue that social ties are important in understanding the economic behaviour of individuals and the success of microfinance initiatives that use group methodologies.

In ISAL groups, social connections, mutual concerns and community values matter. The values are required to participate in ISAL and may be nurtured and strengthened during the operation of the group. ISAL group members may engage in collective initiatives that would be driven by the mutual concern of each to meet survival and well-being expenses.

Kondo and Shirai (2013: 265) provide arguments on the risks associated with expanded social capital. They argue that unguided social capital may lead individuals to be connected to what they call a dangerous external world. There are elements of this social capital that may arise from participation in ISAL. Efforts to improve income generation by individuals may require that

they travel outside of their areas of residence and familiarity, places where they get exposed to various risks. An example is where ISAL members may take loans to engage in cross-border trade of goods bought from other countries such as South Africa. The dangerous external world may relate to the risks of being away from home, travelling and being in a foreign land, exploitation and theft.

2.6.3. Economic empowerment theory

Empowered individuals use knowledge, skills or resources they acquire to satisfy their priority needs. Pakkannaa, Arsyadb and Suryantoroc (2015: 867) argue that the empowerment theory entails a transfer and ownership of capabilities and power to make decisions in a wider scope than economic to include self-reliance, direct democracy and social learning. Organisations that promote ISAL provide training and post-training support, passing knowledge and skills that when applied, allow members to save, access loans and lump sums for use to generate income and meet household expenses. Tanga and Tangwe (2014:188) citing Sadan, define empowerment as a process where individuals change from being powerless to taking control over the direction of their life. In the context of this study, the severity and duration of the sickness of a family member may result in the affected household exhausting its savings and resorting to begging or loans. Such coping strategies can be disempowering as the affected household are dependent on the goodwill of others to meet their needs. The ability of ISAL to change households in such situations to states where they restore self-help could be demonstrations of empowerment.

2.7. CONCLUSION

The chapter presented global and country trends on Aids-related deaths, the occurrence of new HIV infections, coverage of ART and HIV prevalence. The chapter outlined the issues raised by scholars on the effects of HIV and AIDS on the economic status of households by changing the availability of labour for employment and self-employment activities and income generation and spending. The chapter also presented the contentious views on the efficacy of financial services in addressing the vulnerabilities of persons affected by HIV and AIDS. The chapter presented economic strengthening interventions implemented for persons affected by HIV and AIDS in Zimbabwe and those, specifically ISAL, implemented by BHASO for the researched households. The theoretical perspectives applicable to the study were presented.

Chapter 3 presents how the research was designed, the sampling design and processes used in selecting and accessing the study sample, the type of data and how it was collected and analysed, as well as issues of credibility.

CHAPTER 3: METHODOLOGY

3.1. INTRODUCTION

In this chapter, the research methodology used for the study is presented. This includes how the research site and participants were selected and accessed, how the interviews were conducted, the type of questions asked and data collected, and processes followed in handling the data that was collected. This is followed by a presentation of the steps followed in analysing the findings and approaches applied to ensure the credibility of the findings. The final part of the chapter is the conclusion.

3.2. RESEARCH DESIGN

3.2.1. Research method

The research paradigm used for the study is interpretive phenomenology. It entails the investigation of the meaning of experience to the phenomenon by the persons being researched. In this study, the effects of HIV and AIDS on income-earning and spending is the phenomenon. The experiences of research participants with the phenomenon vary and they include emotions, perceptions, decisions, memory, imagination, plans and activities, according to Rodriguez & Smith (2014:96) and Bliss (2016:15). Underlying each of these is the intentionality of the researched on the choices they make within the given phenomenon (Rodriguez & Smith, 2014: 96). The study allowed participants to recall their decisions, actions and relations they associated with their experience with the phenomenon. Bliss (2016:14) states that the concern for descriptive phenomenology is researching the daily experiences of the researched and as they share it, they can attach meaning to them while also creating common sense understanding. In conducting phenomenology research, Rodriguez & Smith (2014:96) argue that the researcher sets aside their perceptions and presumptions and only focus on those of the researched.

The study used the exploratory qualitative research design that used life stories of persons affected by HIV and AIDS to understand the meaning they attached to changes in their income-earning and spending experiences. Life stories, according to Clandinin, Huber, Menon, Murphy and Swanson (2015: 240) and Wang and Geale (2015:195), are used to share and reveal the real-life experiences of the people being researched. The exploratory design was selected considering the need to understand the diversity of both actions and meaning individuals

attached to events. When individuals experience phenomenon, how they live through it can involve complex changes and negotiations that are unique. The experience and meaning of the same phenomenon are not necessarily the same and can be different between individuals. Being affected by HIV and AIDS and participating in ISAL can be a common phenomenon, but the effects experienced by individuals can be very different. This requires the use of a methodology that is appropriate and flexible to allow for the uniqueness and commonality of individual experiences to be recorded. The flexibility does not confine individuals to predetermined categories of the experiences that they share. Rather, they generate their categories as they share their experiences. The method therefore allows for more diversity and richness of perspectives to be generated on the same research questions. Storytelling was used by Parsons, Bond and Nixon (2015) in Zambia, with persons living with disabilities affected by HIV and AIDS, and by Denis (2014) in South Africa, with HIV positive support group members.

Storytelling was selected for the flexibility it provides for participants to share information on how their judgement of their experiences is organised, the cause and effect of the phenomenon and their reaction to it. In doing so, the participants already get involved with interpretation and analysis of research about them. To the researcher, this already points to some of the issues that must be prominent in the overall analysis of the findings. In this study, most of the thematic analysis is informed by the reflections and comments on the experience and the significance of its effects as expressed by the participants.

The researcher recorded life experience not a specific period of the participants. The association of phenomena to different phases of life provides more depth than limiting to moments. Participants were asked to reflect on their past and share their present personal experience on changes to how they generated and spend income. In seeking to understand a complex issue if research fixates on collecting data on a single-phase or time, there is a lot of important detail that can be missed. In the case of this study, focusing on the impact of ISAL on households affected by HIV and AIDS alone would be less vivid and in-depth without understanding the past, and what transpired to get the affected households to their current state. Storytelling allows participants to share and researchers to capture the experience with the phenomenon from a beginning, middle to the end (Moezzi, Janda & Rotmann, 2017). First, this does not confine the participant and researcher to a phase, as would be the case with other scientific methods. Storytelling provides richness in findings. Second, it allows the

participant to unpack the experiences and issues within each phase and the interconnectedness between phases. There is a better understanding of what triggered certain behaviours and actions, the ripple effects and the significance of the experience and the end state to the participant. This provides deeper insights and strengthens the trustworthiness of each story.

Storytelling was chosen for its relevance to how issues related to HIV and AIDS must be viewed from a systemic than individual level. Storytelling allows the participant to unpack issues around a phenomenon and place the reactions, roles and influences of other individuals, community institutions and service providers. According to Moezzi et al., (2017:1), quoting Brown, methods that focus on the individual without placing them in the societal system would miss the influence of intricate and invisible rules that society demands on the behaviour of individuals. At face value, when engaging an individual on their inability to generate income and participate in ISAL, this may simply be attributed to economic circumstances of HIV and AIDS affected participants. While there may be knowledge of stigma prevailing in a community the extent of its impact on economic participation and capability of participants may be less understood. More information may be obtained if the individual can express themselves and be understood within the context of their community.

The choice of storytelling was made for its strengths in allowing for consequences of the phenomenon and experience to be explained and understood in a logical and causal relationship. When illness is experienced at a particular point and context, the participants can narrate how this triggered behaviour such as travelling, availability or non-availability of family labour and decisions on what economic activity to do or not. In their reflection or on being probed, participants can share the middle which is made-up of how the illness-induced travelling, changes in the availability of labour and how types of economic activities influenced either their income-earning or spending levels. Further, the participant can recall and share the connection between the change in income-earning or spending and their ability to cope or not cope with their daily family needs to the change in income and spending.

The researcher wanted a design that allowed the interviewees to reflect and learn from their own experience. This approach leaves the interviewees empowered by reflections of what they overcame and achieved. Individuals reconstructed lived experiences that allowed them to

share the type and depth of challenges and achievements with generating and spending income after participating in ISAL.

3.2.2. Research steps

Access to the study site was facilitated by BHASO staff at different levels. An initial face-to-face meeting was held with a representative of BHASO at the Head Office in the City of Masvingo. The agenda of the meeting was the study, its focus, the targeted sample criteria and size, as well as the areas where BHASO implemented ISAL for persons affected by HIV and AIDS. BHASO staff was requested to indicate whether the planned study was, in principle, of interest to the organisation and their willingness to identify communities interested to participate. The verbal acceptance was followed-up by formal communication to BHASO management seeking approval of the research. The same communication also requested specific support concerning selecting groups, community sites and meeting times for the study and informing the local authorities. The approval and willingness to support were granted by BHASO at head and district office levels. The researcher explained the sample requirements to BHASO field staff, who in turn identified and shared the district and groups that met the criteria. Once the groups were selected, BHASO staff had meetings with each group to explain the planned study for their expression of interest to participate, the specific names of individuals interested to participate and meet with the researcher and the appropriate dates as to when this could happen. This feedback from the groups was shared with the researcher after which community-level one-on-one individual interviews were organised with those who expressed interest to voluntarily participate. BHASO staff accompanied the researcher to the field, which helped in locating study sites and individuals and introductions to the relevant local officials.

3.2.3. Nature of data collected

The data collected for the study was guided by and meant to answer two main related research questions that would lead to an understanding of whether ISAL had supported households affected by HIV and AIDS to earn and spend income to meet their daily needs. Each main research question had two sub-questions that were presented to participants to start narrating their experiences. The sub-questions (generative questions) administered to participants on the first main question on ‘In what way does HIV and AIDS change the way persons affected by HIV and AIDS generate and spend income?’ were:

1. How does HIV and AIDS change the way households generate income?

2. What way does HIV and AIDS change the way households spend income?

The second main question was, ‘How does participation in ISAL by persons affected by HIV and AIDS change their generation and spending of income?’ and had its associated two generative questions as:

1. How does access to ISAL financial services change the way households generate income?
2. How does access to ISAL financial services change the way households spend income?

Regarding HIV and AIDS, the data collected related to when households first experienced its effects and the nature of effects on different members of households, productive activities, the types and number of productive activities, how productivity and income from the activities were affected, the changes that were caused by spending income and the types of expenses that were affected. Follow-up questions were asked to deepen understanding of their experiences of each of the issues.

On ISAL, the data collected was on when participants joined ISAL, what motivated them to join ISAL, the savings amounts made to ISAL, loans and share-outs received from ISAL, the use of the loans and share-outs, how ISAL supported productive activities and income, the types and number of productive activities that were affected by ISAL and the support that ISAL provided on the spending of income. Probing questions were asked on issues for clarification and detail.

Though data was collected from individuals, the experience that was shared and captured related to the households. The approach of using individuals to get the experiences of households was also used with HIV and AIDS affected households by Barber (2011:14) in South Africa.

Consistent with the argument by Wang & Geale (2015:196), each member narrated events as they occurred in particular locations and social settings. The specific location of the participant is important as this may generate a unique experience that would not be transferrable to any other location (Moezzi et al., 2017:2). The experience of a participant with expenses when they are in a rural setting and when they move to an urban location can be very different. Similarly, access to services is likely to be different, which will create a different experience. Each participant shared their experience with social settings, including the HIV and AIDS effect, who

was involved, and the roles played and how and what aspect of generating and spending income was changed. The participants shared names of locations they travelled to as part of demonstrating expenses they incurred or how providing care disrupted participation in productive activities. The reference to past and present, social settings and details on locations make-up the "three-dimensional narrative inquiry space" that Wang and Geale (2015:196) argue is useful in the analysis of narratives. The details are important to understand the nature and extent of the effects of phenomena in ways that are not possible with other methods.

3.3. SAMPLING DESIGN AND PROCEDURES

The target population for the study involved the community members participating in BHASO HIV and AIDS prevention programmes in various districts of Masvingo Province, these included Bikita, Gutu, Chivi, Zaka, Mwenezi, Chiredzi, Masvingo rural and urban. The first sampling step was the selection of the district. The criteria used to screen was the presence of active groups that practiced ISAL and had participated in BHASO HIV programmes. Active groups practising ISAL are those who are known to be meeting and saving and lending regularly. Using these criteria and information provided by BHASO staff, only Gutu, Zaka, Chivi and Bikita qualified to be included in the study. The second screening was considering the district with the oldest ISAL activities by year of the start-up of promotion and training activities. Across and within each district, community members were mobilised at different periods and participated in different programmes providing diverse and differing levels of experience. Purposive sampling was then used to select both the geographical area, groups and individuals who participated in the study. The researcher wanted to carry out the study in an area with homogeneity of having the oldest and most experienced support groups and ISAL activities. This would increase the chances of getting an information-rich sample, a key attribute when using purposive sampling, according to Etikan, Musa and Alkassim (2016: 2). The results of the screening indicated that Bikita started ISAL in 2010, Gutu in 2013, Zaka 2014 and Chivi in 2014. This was followed by a confirmation of the screening with the BHASO staff, which was concurred. This criterion led to the selection of Bikita District, which had the oldest and experienced ISAL groups and members. Also, in Bikita, groups were screened based on those who had the most savings and lending cycles. The maximum savings and lending cycles from 2010 to the time of the study were six. Out of the 100 active groups that were on record, 20 had completed six cycles. The only groups with the most savings and lending cycles were selected, as these would have more in-depth experience with both being affected by HIV and participating in ISAL. Purposive sampling was used to ensure that the

study sample only comprised members who met the criteria of being affected by HIV and AIDS, participating in ISAL, belonged to groups that practiced ISAL and had completed six savings and lending cycles and share-outs. These are the central issues to the study which, according to Gentles, Charles, Ploeg and McKibbon (2015:1778), quoting Patton, make-up one of the considerations when selecting purposive sampling. The next stage of selection was the groups that had pre-set meetings in the week that BHASO field staff was visiting the communities. The researcher did not want to request a special meeting for the study, but for the BHASO staff to meet them during their regular meetings. During those meetings, the BHASO staff would find out which groups had members willing to participate in the study. In the week that BHASO staff were visiting the communities, only four groups were meeting. The final stage for selecting groups was random. When BHASO staff met the groups and explained the study, the first three groups that had members interested to participate in the study were immediately selected. Once members of the 3 groups agreed to participate in the study, the study was not introduced to the final and fourth group.

The criteria for inclusion of participants in the sample were as follows: having participated in BHASO supported HIV services, being a member of an AIDS support group, having experienced an HIV and AIDS-related effect before practicing ISAL, being active savers and borrowers in ISAL and having at least three savings and lending cycles. The criteria also included members who had the longest period of being in support groups and ISAL activities, had experienced income-earning and spending challenges, had households experiencing the economic effects of HIV and AIDS before joining ISAL, had taken loans and received share-outs from their groups. This was important, as these issues related to the substance of the research questions that guided the study. Groups and individuals that do not meet the criteria were not considered. An additional exclusion criterion applied was not interviewing any member who did not voluntarily express their willingness to participate in the study.

3.4. DATA COLLECTION PROCEDURES

3.4.1. Researcher interview notes

The researcher listened to each individual's life story. As participants narrated their experience, the researcher was taking hand-written notes and making annotations. Note-taking was done for the flexibility it allowed to capture and shift between different sections of the notebook as a way to organise any thoughts, issues emerging and follow-up questions. The researcher used

colour coded sticker notes pre-marked with headings that included “Notes” (Yellow), “Follow-up” (Red), “Coding” (Green), “Calculations” (Purple) and “Quotes” (Orange). These were already stuck in blank sections of the notebook. Whenever a relevant issue came-up while taking notes (Yellow), the researcher easily switched between pages guided by the coloured sticker notes. Such flexibility in organising the interview process would not be easy with other methods such as electronic gadgets and voice recorders. The notebook was also easy to use during analysis, as the researcher could easily locate the required text.

Hand-written notes and notebooks were used as they allowed the researcher to draw illustrations such as how participants travelled between places. This included the use of shapes, arrows and circles. The researcher drew sketches of different family and friends from which participants received and/or borrowed money and noting the purpose for each. The annotations helped to visually understand the experiences being shared by the participants. The researcher was also able to underline or insert circles on the text that had significance for follow-up or contributing to codes. Performing such annotations would require more time when using electronic gadgets and not possible with voice recorders.

Handwritten note taking was also selected for the ease in writing, while simultaneously listening to the storytelling and thinking. In some instances, the participants pointed to objects or features of their homestead such as their vegetable garden, house, or asset that had something to do with their story. This process allowed the researcher to write with speed and in the process capture and memorise some keywords and features that were coming from the storytelling.

The researcher also selected handwritten notes as they knew the use was for his sole purpose throughout the entire process of the study. This allowed the researcher to write freely with speed. Where the notes were to be used by another person, the researcher would have needed to be slower to ensure the writing was easily legible.

The main handwritten notes where taken in English. During report writing, some of the quotations of participants that were in Shona were translated by the researcher to English. In Chapter 4 this report presents, in some parts, both the Shona quotations and relevant English translation, while in other parts it presents the English translations only. The researcher did not experience any challenges with managing the translations between the two languages.

The researcher speaks the vernacular language, grew up, studied and lived in the same Province. There was no point during the interview, where Shona words used by the researcher or participants had to be explained or repeated because of misunderstanding. At some point, the researcher worked in the same district where the study was undertaken.

3.4.2. In-depth interviews

Three main phases were followed in collecting data; developing and applying generative questions, probing and evaluation. Before the interview process, the researcher had translated the generative questions into the vernacular language; which is Shona. The questions were then administered in the vernacular language, the reason being that the participants would feel comfortable speaking in their own languages and they would express themselves better than if the questions were addressed in English.

In using elicited narratives, the researcher asked questions that were focused on a particular topic, to initiate the storytelling. As stated by Flick (2014: 266) and Paavilainen-Mäntymäki & Aarikka-Stenroos (2013:140), quoting Flick, generative questions were used to initiate storytelling. After the introduction and informed consent formalities, the researcher asked generative questions that were in four parts.

In Part 1, each participant was asked the generative question “When and how did HIV and AIDS change the way your household generated income?”. This question sought to hear when the participant experienced the energy, the effect of HIV and AIDS that changed how their household generated income. They also explained the nature of the change, whether levels or frequency, caused by HIV and AIDS. The participant answered the question in as far as they wanted to talk. In all the 9 narratives, they were consistent in referring to how they were generating income in the past, as part of their explanation of the change after the HIV and AIDS phenomenon. When the participant paused, they were asked if they had said all they wanted. After their confirmation, Part 2 of the generative question was asked.

In Part 2 of the interview, the participant was asked a follow-up and related question on "What way did HIV and AIDS change the way your household spends its income?". In the first part, each participant would have identified where and how in their economic activities, HIV and AIDS had affected. This varied from the type or number of economic activities, frequency or location of operation, frequency or level of income and which family member was involved or

not. But this did not tell how in the story this had affected how the participant's household spent their income. In Part 2, the participant shared the connection between the change in income generation to how and for what and their ability or not to meet their household expenditure needs. As in Part 1, each participant was given the open time to narrate their experiences until they paused and confirmed having exhausted all they wanted to share. At this stage, the participant would have shared their predicament and wrongs of their experience.

In Part 3, the research was very particular on questions that elicited experience about the promotion of ISAL and the participation of the participants. Storytelling is also about the resolutions that participants make in situations they faced, such as finding solutions and coping or transforming their circumstances (Brown, 2017 quoting Sarbin). To determine if ISAL was selected and used as a resolution to any predicaments, the participants were asked the generative question: "When and how did access to ISAL financial services change the way your household generated income?" Each participant had the space to narrate their experiences related to the question. The experiences were only about the generation of income that they associated with being in ISAL. These could be about the sources, frequency and levels of income. The change in income after ISAL did not tell whether this translated to change in the participant's spending patterns.

Part 4 of the interview process sought to establish how participating in ISAL changed how the participants spend their income. They were asked, "How did access to ISAL financial services change the way your household spends its income?". They shared their experiences on what they spent their money on, the frequency and timing of spending. They also referred to their predicaments and failures during the period (middle part of storytelling) they experienced sickness to emphasise the change they associated with ISAL.

On select occasions, during each of the parts, the researcher would ask the participant to clarify or explain unclear or incomplete words or narrations. After the clarification, the researcher read-out the last experience the participants had narrated before the interruption. They would then be requested to proceed with the storytelling.

At the end of storytelling, the researcher flipped to the part of the notebook marked with a red sticker note. In that part, the researcher had noted questions and significant issues that were either not clear or incomplete and needed follow-up. Examples are, where the researcher

probed by asking why certain decisions and actions were taken, why a participant felt the experience was an achievement or disappointment, what was the meaning to the participant of a certain experience and where certain experience occurred and who was involved. Paavilainen-Mäntymäki and Aarikka-Stenroos (2013:141) argue for the important role that probing plays to get more information and for participants to share an in-depth experience.

When the general notes were being recorded in the yellow section, the researcher marked narrations which he believed were befitting to quote and would be used in the reporting. The researcher went back to the annotated notes to read out the statements that were made and asked the participant to confirm if what had been captured was correct. If this was correct, the researcher highlighted the notes with a green marker pen. Where there was a correction from the participant, this was handwritten in the orange section of the notebook.

During storytelling, the researcher noted the participant's body language, sighs, elation, contemplation, exclamation, pauses and where they made rhetoric questions. These were noted in the red-sticker pages. The researcher noted the issue that was being narrated when the signal was observed. In the end, the researcher followed-up with the participants to understand the significance, meaning and learning about the issue by asking the what, how and why questions. Wang and Geale (2015:195) argue that this is a key advantage of using storytelling, it provides the flexibility to follow-up and probe findings to gain a deeper understanding.

Evaluation and closure

After the storytelling and exhaustion of the issues for follow-up, the researcher asked each participant a reflective question on "Are there any experience that your household could have wanted to be different?" This allowed the participants to evaluate their experiences in the past and current status of income-earning and spending. This also allowed them to find meaning, learn and change from their experiences. These are characteristics of narratives, as outlined by Haydon, Browne and van der Riet (2018:127).

3.5. ANALYSIS OF FINDINGS

Thematic analysis was applied to the collected data and this involved several processes. The first step, organising the data, occurred daily during and after each interview. While interviewing, the researcher immediately noted the theme and the specific quotation. To

ensure the theme and expressions were correctly captured, the researcher read it out for confirmation or edit by the participant. The voice of the information source transcends the analysis. This is not possible, with some of the quantitative methods where interpretation and analysis are conducted by the researcher. Mauk (2014:226) argues that data analysis should start when data is being collected and not at the end of the research process. This was applied in this study, as during the recording of the life stories, the researcher promptly recorded both member and researcher interpretive insights that emerged from each narrative that could be useful for the next level of analysis. A few examples occurred, such as when a participant mentioned how sickness forced them to stop producing certain types of crops, the content insight the researcher promptly recorded was on “decision to change the types of crops grown". In another case, a participant mentioned having reduced the number of crops they grew, and the recorded insight was "change in the number of crops grown." These initial interpretive insights were important in subsequent coding and categorisation. The commencement of analysis with the first interview to inform coding and categorisation of the findings was in line with one of the options in approaches to analysing narrative findings, according to Flick (2014: 44).

The second step in the analysis was reading through the written notes, in between interviews and in the evenings at the end of each interviewing day. Each narrative was read through at least three times as a way for the researcher to gain an in-depth understanding and familiarisation with the story.

The third step was data reduction, where the researcher took notes of further insights and quotations emerging, adding and refining to what was already captured during the field interviews. This step was very important as it allowed the researcher to develop more content references and refine those developed in the field.

the fourth step was an on-going daily comparison of findings between member narratives. The comparison was identifying and noting similarities and differences on issues and their recurrence and the emergence of new issues. The motivation for comparison was the shared characteristics of the interviewed individuals, such as being members of support groups, affected by HIV and AIDS, practicing ISAL and membership to the same groups. These commonalities provided the basis for comparing findings and refining the thematic content as argued by Nicola, Gale, Heath, Cameron, Rashid and Redwood (2013: 3).

The fifth step in the analysis was identifying patterns across stories. The researcher referred to field notes and reading notes to identify issues that, in the expressions of members interviewed, were either recurring in one case or common in at least two or more stories. An example, where an issue recurred in the same case was where the change associated with HIV and AIDS was the use of seed reserved from past harvests and the related change in spending was not affording to buy improved seed varieties. In identifying patterns across narratives, the analysis recorded when the same issue emerges in another story, though probably narrated differently. Building on the example above, another member could have referred to using seed varieties not appropriate for the context such as seed reserved from past harvests.

The sixth level of analysis was developing codes from themes that emerged from the previous steps. In the examples of agriculture inputs above, the codes that were generated were *the affordability of inputs* and the *use of substitute inputs.* Each code was written on a piece of card. As each story was analysed, these codes could be maintained and the names of members whose stories fitted in the same code were noted. New codes were added as each story was analysed.

The seventh level of analysis was reviewing the codes and seeking to understand their meaning to the purpose of the study and how they contributed to answering the research questions. Examples being the changes that increasing healthcare expenses caused to the ability of households to pay for other basic expenses. As households spent more on the healthcare, they could not pay for education expenses, leading to the withdrawal of children from school. In other households, they stopped market-based food purchases to save available cash for healthcare expenses. Beyond the research questions, the analysis also considered placing the findings within existing theoretical constructs. This included how participating and benefiting from ISAL activities and the restoration of the capacity of households to meet their daily needs could be understood using the three theoretical frameworks outlined in the previous chapter.

3.6. TRUSTWORTHINESS OF THE STUDY

3.6.1. Authenticity

Drawing similarities or differences across stories is an approach that can be used to bring reality to the findings (Noble & Smith, 2015:34). The study considered the authenticity of findings where there was an experience that was similarly shared and corroborated between interviewed members, whether they were in the same or different groups and locations. While interviewing members of the Progress support group, P4 shared their experiences of receiving asbestos roofing sheets from their group. As P5 also shared his experiences, he indicated having built his homestead through the initiative of the Progress support group. The researcher then asked P5 if the initiative of the group was the same or different from what P4 had shared about asbestos roofing. P5 confirmed that being the case, which gave authenticity to the stories.

The study sample comprised individuals who shared similar characteristics, such as having experienced HIV and AIDS, belonging to support groups and ISAL activities and at each site, members residing in the same villages. These provided a basis for considering points of corroboration. Areas observed with similarities for corroboration included the amounts saved during meetings, share-outs received at the end of cycles and the proceeds such as groceries received from groups. In all 9 stories, it was common that when participants narrated their experiences in Part 3 of the interview, they did not mention how much they were saving in their groups. This was an issue recorded in the “Follow-up” part of the notebook. In all cases, the participants were asked “How much money are you saving in your group?” and “Is this the same amount that you were saving when your group started?”. Participants who belonged to the same group stated having saved the same amounts during meetings, without being informed of the amounts that others had mentioned.

In Star and Progress support groups, the participants narrated that their groups had reduced the amounts they saved when the groups started to what they were saving at the time of the study. This was noted by the researcher as an issue for follow-up and use in determining the authenticity of the stories. During the clarification and probing phase, the researcher asked the participants “What were the amounts you saved at the beginning and what are you saving now?” and “Why did your group change the savings amounts?”. In all stories, the participants mentioned the same amounts and gave the same reasons for the adjustments that were made. In all cases, members from the same groups recalled the same amounts they received as

share-outs. Members who belonged to groups that bought and shared bulk groceries mentioned the same types of items and frequency of receiving the goods.

Authenticity was considered in the corroboration of the chain of events. An example was how the P1 of Star support group explained how she got to hear about ISAL and the sequence of activities that happened after. This was noted as an issue for follow-up and the point at which stories could be corroborated. During clarification and probing, the researcher drew on a blank page, using boxes and arrows, the sequence of activities. This included the AIDS support group district meeting, orientation meeting at village level with BHASO staff, time for individuals to decide on an interest in ISAL and training of group on ISAL by BHASO. The annotations of participants from the same groups corroborated the same experiences on the process leading to their joining ISAL.

Despite the points of corroboration, the study also considered the diversity of experiences and perspectives as elements that increased the trustworthiness of the findings. This helps to demonstrate how the findings were not managed and influenced to align with particular perspectives, but those of individuals sharing their experiences. The participants who were interviewed had varying circumstances on issues such as the nature and timing of sickness. In Part 1 of the interview process, each participant mentioned the year and even month when their household first experienced the effects of HIV and AIDS. While still in the community, the researcher checked the notes if members from the same group gave the same dates or not. There were no similar dates. As participants shared their experiences, they voluntarily mentioned the locations where sickness was experienced and where healthcare services were sought. At the end of each day, the researcher checked and highlighted the names of locations that were mentioned at each site and most of them were different. For all the 9 participants, at some point during sickness, they sought healthcare in the local district. They also sought healthcare services out of their district, but in different places such as Harare, Masvingo and Mutare. The researcher also noted what each participant narrated about the composition of their families, means of earning and levels of income, to determine any similarities or differences. Whether members were in the same or different groups, there were none with the same experience. While all members were small-holder farmers, they grew different crops, owned different sizes of land and numbers of livestock. These variations influenced households to experience change differently. The social and economic phenomenon generates an experience that would be unique to certain households and not all. This analysis

of elements of diversity aligns with the argument by Lewis, Ritchie, Ormston and Morrell (2014:361) that social phenomena cannot have a single perspective.

The researcher noted points and perspectives where participants shared specific details that could be used to raise the trustworthiness of findings. A particular detail looked for was time, which according to Squire (2013:50), can be converted into a narrative mode. In other words, it becomes important in how participants can recall and express their experiences. The generative questions in Part 1 and Part 2 were very specific in asking "When" HIV and AIDS and ISAL changed the circumstances of households. Participants shared the dates. Also, all of them, at different points, voluntarily shared several time-related details. Across the participants, this variously included from specific number of years when sickness was experienced, years when crop harvests declined or increased, months when participants received groceries from the groups, the specific names of assets and groceries that groups bought for members and the number of times participants bought medicines, as well as the frequency of visits to health facilities.

At the end of each interview, the researcher summarised the understanding of each experience to allow for verification and validation by participants. The summary included the content on major changes to income generation and effects on spending, the household members who were affected and involved. Participants immediately corrected errors and misinterpretations, volunteered additional information and confirmation. Dalal and Priya (2015:14), as well as Rubin and Babbie (2015:451), refer to this as member checking.

The researcher transcribed each life story as narrated. The notes included the time interviews started and ended, issues that required follow-up and experience likely to emerge from other stories and to be cross-checked. Maintaining this audit trail was a way to confirmability of findings, which also contributes to trustworthiness, according to Erlingsson and Brysiewicz (2012).

3.6.2. Credibility

The researcher noted moments when participants referred to witnesses of some experiences as moments that brought credibility to the findings. An example was where some participant referred to hospital officials who could testify to the condition of the sickness of their family members or themselves. Fellow community members were mentioned as witnesses of how

some participants had become known as regular beggars. Other individuals referred to school officials who turned their children away from school after prolonged periods of non-payment of fees. Participants referred to friends and relatives who, at the peak of sickness, provided financial support, either as handouts or loans. Some witnesses were other participants belonging to the same support groups who could testify having received the same benefits from ISAL. Also, references to objective events and/or locations were sought and captured for credibility. For example, a note was taken when participants mentioned, without being asked, their or a family member's hospitalisation and the location of the hospitals. Wang & Geale (2015:196) refer to the importance of location in giving meaning to narratives and how this may have influenced the experiences of the participant.

3.6.3. Reflexivity

At the onset, the researcher was alert to how his unfamiliarity with those to be interviewed, and how their presence in the community could influence the participants as they responded during the interview processes. In the first instance, the researcher focused on establishing familiarity with the participants for them to be comfortable to talk. Towards this, as part of the self-introduction, the researcher shared from a facilitator perspective, his knowledge and experiences with the ISAL methodology in Zimbabwe. Reference was made to the districts and communities in the country where the researcher was once involved with ISAL. Some individuals recalled having heard about some of the ISAL work in the district. The familiarity shared on the methodology helped participants not to explain some basics of the methodology to the researcher, but to focus on their own experiences. This also helped when the researcher asked follow-up questions on ISAL specific terminology, such as share-out and social funds. Without sharing the researcher's familiarity with ISAL, some participants would have wondered how such terms were known. As Van Schalkwyk and Gobodo-Madikizela (2015: xix) argue that not sharing the researcher's experiences would have risked creating a distance with the participants. Despite this, the participants were reminded that they were the owners and drivers of ISAL and the interview was about their experiences.

The participants expressed appreciation in having a researcher who listened and took notes of details of their verbal and non-verbal expressions. This was an important relationship-building approach between the researcher and the interviewees. This is regarded as important, as according to Edwards and Holland (2013:17), it is the interface that creates knowledge.

3.7. ETHICAL CONSIDERATIONS

An initial ethical clearance for the research (see Appendix A) was granted by UNISA's Department of Health Studies. Also, further actions were applied in conducting fieldwork, presentation of the findings and storage of the field notes. The actions were meant to protect and uphold the privacy and anonymity and the rights of the individuals who were interviewed. These ethical issues must be considered when conducting qualitative research (Erikson, 2016:114; Wang & Geale, 2015:197).

3.7.1. Anonymity of interviewees

The identities of the nine interviewees are not revealed and instead, pseudonyms, the numbering of interviewees, is used. This was explained at the beginning of the interview process and they all agreed, though some had expressed that they did not mind having their names included.

The notes for all the interviewees are locked away in a metal cabinet at the residence of the researcher and where he has sole access.

3.7.2. Privacy and protection

The interviews were conducted with each individual in private and away from hearing or interruption from others, in order to give privacy to participants and the data collected. At two sites, interviews were conducted in closed-door rooms. The interviewer and interviewee could not be seen and see other people, as this could potentially affect effective involvement in the interview process. At one site, where there was no closed-door space, the interviews were conducted at a secluded open space that was more than 100 meters away from other people. In both locations, the members were first asked if they were comfortable to be interviewed at the selected place, which they affirmed.

3.7.3. Informed consent and voluntary participation

An informed consent letter (see Appendix D) was read out in the vernacular language for the members to give their verbal response. A printed copy was given out to each interviewee to read. A UNISA template was also used to guide the explanation to participants on the academic purpose of the study, the name of the institution where the studies were undertaken, the types of questions to be asked, the contact details of the supervisor to whom complaints could be directed, and the right not to answer and to end the interview at any point. The

researcher explained the maximum two hours duration of each interview for members to feedback on whether they had such time. Each member was allowed to ask questions and decide on their willingness to participate. Questions that were asked at this stage only related to whether the study was being conducted with all groups and individuals in the district, which were responded to. Interviewees were informed to let the researcher know whenever they needed to break and end the interview process if they were tired or had other commitments. This step was important and in line with the argument by Monette, Thomas, Sullivan and DeJong (2014: 54), that informed consent must involve telling respondents all aspects of the research to help and influence their decision to participate or not.

Each participant was asked if they had understood the purpose of the study and the kind of information they were to be asked. They were allowed to ask questions regarding the research, which were addressed. After questions were addressed, the participants were asked verbally if they wanted and were comfortable to participate in the study or not. They were requested to give their decision verbally, which was affirmative for all cases. The study covered only ISAL members who verbally voluntarily accepted to be interviewed.

3.7.4. Incentives to participants

The study did not include the provision or promise of incentives for participants to participate, whether during or after the interview process. Incentives could include pay-outs of cash or in-kind gifts given to interviewees in exchange for being interviewed and sharing information that they would not ordinarily share without incentives. The researcher determined that this would likely force participants to share inaccurate information or feel coerced to participate, which would not be ethical. From the onset, to prevent and mitigate the risk of deception and raising false expectations, the researcher explained to the participants that there was no promise of any material or non-material reward during or after participation in the study, neither from the researcher nor from BHASO. It was explained to each individual that the researcher would also not receive any material rewards for the study. This needed to be outlined at the onset, for information to be shared voluntarily and freely.

3.7.5. Doing no harm

At the beginning of each interview process, the researcher explained that the process of narrating life experiences could potentially lead to reliving or recalling events that could bring unpleasant memories and feelings and the risk of psychological harm and distress. The

researcher explained that though the study was about economic circumstances, this had intricate links to the social and psychological state of the participants. The researcher explained how talking about death, sickness and suffering of one's nuclear family could open fresh wounds of pain. Also, if there were unresolved issues from that experience, this may emotionally affect the participant. This was imperative, as according to Richards (2015:15), the probing in qualitative research can be intimate and intrusive and, in the process, bring risk and harm to those being interviewed. This was even more critical as the study dealt with a sensitive and stigma-laden issue; HIV and AIDS. Examples given to interviewees included memories of the loss of assets, sickness, death of family members, the struggles and shame that could come with behaviours such as begging. During the interview process, the researcher did not probe on issues related to sickness and death beyond what was voluntarily shared, in a way to reduce the risk of harm. It was explained that at any moment, if an issue was deemed sensitive and the interviewee was uncomfortable with sharing their experiences on it, they should let the researcher know. Also, they had the right not to share such experiences and could call for an end to the interview process, without any pressure on them to account for that. As Khan (2014:231) argues, such explanations are important as they alert those being interviewed of the potential harm from the process and the role they could play in preventing that.

The researcher also explained the availability of BHASO community resource persons that could be approached for support on any effects arising from the interview process. This information was shared at the beginning and end of the interview process. At the end of each interview, the participants were specifically asked to share any concerns or support they needed arising from the effects of the process. In all cases, there were no issues raised.

3.8. CONCLUSION

Storytelling, a qualitative research method, was used to understand how participation in ISAL supported the way persons affected by HV and AIDS generated and spent income. The study area and population were purposively sampled. The life narratives were recorded using written notes. Each interview had three main phases: from asking generative questions, probing and evaluation. Data analysis started with the first interview, developing and comparing themes and codes between and after each story. The themes were analysed to understand their meaning and contribution to the purpose of the study. The authenticity and credibility of findings were achieved by taking notes following the logical sequence of events, corroborated

actions, the exactness of details and the diversity of experiences. Ethical considerations applied included the use of pseudonyms, the use of closed-door and secluded locations for interviews, obtaining voluntary willingness to participate, informed consent and sharing interview risks and their mitigation.

The next chapter presents the study findings, including a brief profile of each interviewee and consolidation of themes from the nine life stories and guided by the research questions.

CHAPTER 4 - FINDINGS

4.1. INTRODUCTION

Tis chapter presents findings on how participation in ISAL supported the way nine households affected by HIV and AIDS generated and spent their income. The chapter starts by presenting the profile of the nine participants, including their gender and age disaggregation, the duration they experienced the effects of HIV-related sickness, as well as when and why they started practising ISAL. This is followed by the presentation of the consolidated findings of the study. First, presented are the findings related to how HIV and AIDS changed the way the participants generated and spent income. Second to be presented are the findings on how participating in ISAL changed the different areas of the manner in which the participants generated and spent their income. The chapter closes with a conclusion.

4.2. CHARACTERISTICS OF THE SAMPLE

a. Profile of sample

The participants were nine (9) members of households that were affected by HIV and AIDS. The sample participants experienced the effects of HIV related sickness for between 2 and 7 years and had, at the time of the study, participated in ISAL for between 3 and 5 years. They represented three (3) HIV and AIDS support groups and five (5) Internal savings and lending groups.

Of the participants, seven (7) women and two (2) men were members of Support Groups formed by BHASO. There were four (4) participants aged between 30 and 39 years, three (3) were aged 40 to 49 years while two (2) were in the 50 to 69 years age range. Saha et al., (2015:1513) conducted a study on the effects of combining health programme and microfinance, but the findings did not show any correlation between age and marital status. The study sample had adult household members aged between 30 and 69 years. There was no household member whose story indicated their age as an important characteristic of the changes in income-earning and spending caused by HIV and AIDS and participation in ISAL.

Challenges of poverty and the ability to pay for the educational needs of children are documented and so is the entrenchment of these arising from the effects of HIV and AIDS (Ssewamala, Leyla, Neilands, Shu-Huah, Chang-Keun, Vilma & Proscovia, 2016). Six (6) participants had children who were enrolled in primary and secondary school at the time of the

study. Of the nine participants, eight had school-going children when they experienced the effects of HIV and AIDS. Having children influenced how households experienced the changes caused by HIV and AIDS on productivity and prioritisation of spending decisions. Children had food, health and education expenses whose access was affected by the effects of HIV and AIDS on income earning. The greatest change experienced was related to the inability of households to pay for the educational needs of their children, leading to school dropouts because of the burden of healthcare expenses. Households shared how participation in ISAL enabled them to pay for the educational costs and re-enrol their children in school. Households that restored their ability to pay for the education and food needs of children expressed a great sense of satisfaction and achievement.

Eight participants were married, at the time they experienced the effects of HIV and AIDS. Marital status had a significant effect on how households experienced the changes HIV and AIDS on participation in productive activities, earning and spending income. Before the effects of HIV and AIDS, spouses contributed to household income, either directly providing labour to productive activities, or income from wage employment. After the effects of HIV and AIDS, the labour of both spouses became irregularly available to productive activities or lost because of sickness. Also, the spousal obligations for care and support diverted the labour of household members from productive activities.

All participants knew about ISAL through meetings and training facilitated by BHASO. The ISAL activities were practiced through support groups, meaning every member of the support group was involved. This approach of using HIV and AIDS support groups as platforms for promoting ISAL methodology is similar to what SaveAct used in South Africa (Barber, 2011:8). Participants 1, 2 and 3 belonged to Star support group, while Participants 4, 5 and 6 were in Progress support group and the remaining Participants 7, 8 and 9 belonged to the Persistence support group. Star support group that had 14 all-women members was formed in 2013, while Progress with 23 men and women members was formed in 2011 and, subsequently, Persistence group, with 55 men and women, was formed in 2011.

Three participants belonged to two other groups that were formed to solely practice ISAL with other community members that were not part of support groups and not necessarily affected by HIV and AIDS. The two groups were Overcome and Pride and these were not trained by

BHASO. In formatting these groups, the desire was to save more money than in the support groups.

b. Profiles of individual household Participants

Brown (2017:218), quoting Sarbin, states that storytelling must have three parts; a beginning, middle and an end. This section presents the beginning of the experience with sickness for the nine participants. The participants narrated the nature of the HIV and AIDS-related experiences of their households. The time realm is one of the characteristics of stories and storytelling (Moezzi et al., 2017:3). The narrations of all participants included when the sickness was experienced by their households.

Participant 1

Participant 1 (hereafter referred to as P1) experienced changes to how their household generated and spent income because of HIV and AIDS in February 2006. At the time, the household experienced a sickness that was not immediately, but later associated with HIV. The household had recurrent sickness of P1's husband, incurred consistent expenditure on local remedies and constantly lost his labour from productive activities. The household did not seek hospital care for the only reason that they thought the sickness would pass. The household also had a child who experienced HIV related sickness with additional effects on how income was generated and spent. P1 was a member of Star support group where ISAL was introduced in April 2013. The motivation for P1 to participate in ISAL was the success stories of support group members from neighbouring villages, the challenges her household experienced with paying for healthcare expenses and the loss of her husband's regular wage. P1 believed that their healthcare expenses were permanent, and this demanded her to work hard to improve the level of income they earned. When P1's group started ISAL, each member saved $5 per month, this was adjusted to $2 after a few months to bring relief and encourage all members to regularly save. P1 had three children enrolled in primary and secondary school.

Participant 2

Participant 2 (hereafter referred to as P2) and her household experienced how HIV and AIDS changed income-earning and spending in July 2007. P2's husband had recurrent headaches and bouts of coughs that incapacitated his participation in productive activities. The household did not immediately seek healthcare services, but always bought local remedies. P2 belonged to the same Support Group as P1 and participated in ISAL activities at the same time as P1.

P2 initially feared she would not raise the $5 monthly savings as her household was already experiencing challenges in meeting daily expenses and did not want to add another burden. She was encouraged by other support group members to participate in ISAL. Her additional inspiration was the pursuit of self-help, not using the health situation in her household as an excuse for not being productive. She failed to save on her own and wanted to try in a group. The household had one child enrolled in secondary school.

Participant 3

In May 2010, Participant 3 (hereafter referred to as P3) experienced how HIV and AIDS changed the manner her household earned and spent income. This was after six months of her sickness and being bedridden and not regularly active in productive activities. She immediately had tests undertaken to determine the cause of her sickness and receive treatment. She belonged to the same support group as P1 and 2 and practiced ISAL in April 2013. P3's initial pessimism on ISAL arose from doubts on her capability to raise regular savings as her household already had challenges to pay for daily needs. She was encouraged by stories of ISAL from other parts of the district. She had the desire to prevent the recurrence of her household's painful experience of not affording health, food and education expenses and the sense of helplessness she felt when begging and taking loans. She wanted to be with other persons affected by HIV and AIDS who strived to improve their well-being and being self-fulfilled by accessing loans from savings she and others made. Her household had five children enrolled in primary and secondary school.

Participant 4

The change to income-earning and spending caused by HIV and AIDS was experienced in July 2004 by Participant 4 (hereafter referred to as P4). P4 was sick, which affected his regular attendance to work and occasionally demanded support from other family members because of his visual impairment. The local District AIDS Action Committee used to provide P4 and others with drugs but not the desired food. He and others realised that they would not always get the support they wanted and was eager to use his efforts to meet household daily needs. He joined Progress support group that started practicing ISAL in April 2011. Then he did not see how ISAL would fulfil his desire for self-help and could not conceptualise the value of borrowing one's own money. He went by the majority decision to practice ISAL and each member saved $5 per meeting, an amount which was adjusted downwards to $2 as some members failed to raise the initial amount. P4 raised his initial savings from the pension he

received from the National Social Security Agency. After 7 months in ISAL, the group had about $420 and members were taking loans as high as $60 and this made P4 highly motivated by ISAL. P4 had one child in secondary school.

Participant 5

Participant 5 (hereafter P5) started experiencing changes in earning and spending income associated with HIV and AIDS in November 2010. He experienced a sickness that forced him to stop his productive activities. He started practising ISAL with Progress support group in October 2012. P5 reflected on his experiences of sickness and the challenges of meeting food and health expenses. He had no savings, and neither could he access loans from local financial service providers. The local community no longer felt sorry for persons affected by HIV and AIDS, as many who lived positively had successful IGAs. P5 accepted he would not receive hand-outs to meet his needs. He desired to change his situation and pay for his needs by re-engaging in IGAs but needed an opportunity to access capital. He saw ISAL as the opportunity to achieve his aspirations. He was also encouraged by experienced support group members who were involved in IGAs. His initial challenge with ISAL was how to raise the $2 savings since he had no regular income earning source. He had a household with three children enrolled in primary and secondary school.

Participant 6

In June 2008, Participant 6 (hereafter P6) and her household experienced changes to household income-earning and spending they associated with HIV and AIDS. First was P6's husband who fell sick, though they did not immediately know that the sickness was related to HIV. P6 also got sick and immediately had tests at the local health facility from which she also received treatment. P6 started practicing ISAL in April 2011 as part of Progress support group. P6 had failed to meet her household's daily expenses for food and healthcare and had no savings, yet she faced emergencies that left her helpless and resorting to begging and accumulating debt. This experience was her main motivation to participate in ISAL. The opportunity to save appealed to her as she had in the past planned to do so at home, but had consistently failed as she always withdrew the savings and lacked the motivation. Her household had six children in primary and secondary school.

Participant 7

In October 2007, Participant 7 (hereafter P7) and her household experienced changes to income-earning and spending caused by HIV and AIDS. Her husband became sick for some months and stopped working. The household believed the sickness was ordinary and local remedies would help and did not use hospital facilities. ISAL was introduced in August 2011 to the Persistence support group where P7 was a member. Her motivation to participate in ISAL was the helplessness she felt during sickness and the desire to restore assets that her household had disposed to meet urgent healthcare expenses. The influence of peers weighed heavily on her participation as the group repeatedly encouraged members to stop using their HIV status as a reason to be lazy and expectant of hand-outs. P7 desired to restart her cross-border buying and selling IGA. She approached friends and relatives for loans without success and saw her solution in the opportunity to access loans from ISAL. Though she initially struggled to raise the monthly $2 savings she found the means by engaging in paid piecework on other people's land and fetching and selling firewood. Four children in P7's household were in primary and secondary school.

Participant 8

Participant 8 (hereafter P8) and her household became aware of how HIV and AIDS changed the way they earned and spent income in September 2011. P8 was recurrently sick and spending more time bedridden, seeking healthcare services and not actively involved in productive activities. P8 participated in ISAL in February 2012 as a member of Persistence support group. Her motivation for ISAL was the desperation to address her family's challenges with expenses for healthcare, food, education and clothing. Though she appreciated the support from her parents, she wanted to relieve them of the burden and instead support them and restore her household's capacity to provide for itself, including paying for every hospital visit. She had the aspiration to restart all her productive activities but lacked the capital. Initially, she was not convinced about the appropriateness of ISAL to her circumstances and her ability to raise the required savings. She however participated and provided her labour for cash or in-kind payments to raise the $2 monthly savings. There were three children enrolled in primary and secondary schools in the household.

Participant 9

Participant 9 (hereafter P9) experienced how HIV and AIDS changed the manner in which her household earned and spent income in January 2008. This was after her sickness that extended for more than six months during which she stopped operating her IGA and was

incurring healthcare costs. A test at the local health facility revealed the cause of the sickness and she received the prescribed treatment. She started practicing ISAL in February 2013 with the Persistence support group. Her motivation to be involved in ISAL was the observation she made of existing support group members whose lifestyles were different and thriving as they met their needs despite being affected by HIV and AIDS. She witnessed how they annually received groceries from their groups and engaged in IGAs. She aspired to always provide food for the family, pay for her children's education and scheduled hospital visits. Her household had three children in primary school.

4.3. FINDINGS: MAJOR THEMES

This section presents the consolidated findings based on themes generated from the analysis of the nine stories. The findings are organised such that each of the two main research questions is presented with the associated findings from follow-up and probing questions. When research participants narrate stories, there must be protagonists and characters associated with the story being told (Moezzi et al., 2017). In presenting the findings, the participants are the protagonists; leading characters. As they existed in households and communities their families, friends, and relatives, neighbours and groups are characters, who are brought into the stories as they variously engaged and generated the experience of the participants.

4.3.1. How HIV and AIDS changed the way persons affected by HIV and AIDS generated and spent income

Brown (2017: 218) quotes Sarbin, argue that stories must have plots and within these plots are the human predicaments of the participants. In this study, the predicaments in the experience of participants relate to how the onset of HIV and AIDS in their families changed the levels or sources of income and adequacy or not, of the income to pay for different types of expenses. The predicaments created personal truths for the participants, which from their experiences helped them to define what was right or wrong (Brown, 2017: 218). In the findings of this study, the wrongs were the negative experiences that the participants had with their inability to generate income and meet their household needs.

In this section, the findings presented relate to how the nine participants experienced the way HIV and AIDS changed their generation of income. The findings show that HIV and AIDS reduced participation in productive activities and the levels and frequency of income generated

by the affected households. These influenced the changes in how households spent income on their daily needs.

a. Effects of HIV and AIDS on household income generation

Moezzi et al., (2017:3) state that in storytelling, there has to be energy which can be something that happens and triggers a change in the state and experience of the participant. In this study, the HIV and AIDS-related energy that drives the change experienced by households in income generation was sickness. The participants shared their experience of how having sick members in the household reduced the family labour that was available to participate in productive activities. For some participants, the availability of labour was directly reduced when family members were sick and could not work. In the case of other participants, those who were not sick provided care and support, thereby preventing them from participating in productive activities. There was common experience that was shared that alluded to participants abandoning productive activities and how this subsequently led to a decline in operations and income. The participants shared their sense of dis-empowerment. What they experienced is against the empowerment theory, where one indicator expected of empowered households is growth in productivity (Navabakhsh, Azkiya, Vosouqi & Estekhareh, 2015: 7).

The experience of several participants with income generation demonstrated the importance of social capital when households are affected by HIV and AIDS. Participants relied on different forms of financial support from relatives and friends. The transactions were made possible because of the friendship and family relationships they had. These structured relationships between people and membership in networks, as argued by Álvarez & Romaní (2017:58), constitute their social capital. At some point, participants who relied on income support, whether donations or loans, narrated how this declined during sickness. As will be shown in the findings they felt unease with begging or asking for loans, as this created an unequal financial relationship with those who supported them. In their communities, this behaviour was also negatively viewed as a sign of failure in family responsibilities. This showed a change to low levels of social capital. In the social capital theory, as argued by Ransome, Galea, Pabayo, Kawachi, Braunstein, & Nash (2016:3), when individuals feel economically unequal to others, this can lead to the erosion of social capital.

Reduction in labour participation in productive activities

In all 9 stories, the direct and indirect loss of labour in productive activities was the most mentioned change induced by sickness. P1, P2, P6, and P8 narrated how they experienced this change very early into their sicknesses before the HIV status was known. The experiences of the 9 participants was that when family members fell sick, they no longer, either partially or wholly, had their labour available in productive activities as in the past. They referred to the past when the sick labour used to be involved in different yet key household activities largely in the production of crops:

> *Murume wangu akagwara zviya zvekuti aisakwanisa kushanda pamabasa ose amavoko ayienderana nezvekurima. Munguva yakare ndiye airima minda yose yedu. Vaivapo pose pataisakura nekutakura gohwo kubva kuminda. Kubva pavagwara vakanga vasingachakwanisi kuita zvose izvi. (My husband was so sick, that he did not participate in many labour-intensive agriculture activities. He used to till all our arable land. He was also involved in weeding and transporting crops. Since his sickness, he could not undertake any of these activities as before.) (P1)*

P4, P5, P6, and P7 who at some point were sick, narrated how they were forced to reduce their presence and time in IGAs after sickness. As the primary operators of the IGAs, they could not make their labour available to some of the productive activities.

> *I used to sell shoes, sandals, blankets, purses, satchels, and perfumes among other items that I purchased from South Africa. I walked to different villages and business centres to make sales. A sickness that I had from February of October 2007 got worse in December 2007. On some days, I could not leave my homestead. I cut the frequency of my travel to South Africa. (P7).*

The narratives of P1, P2, P3, P5, P7, P8, and P9 revealed how the household labour did not require to be regularly resident at home all the time to participate in productive activities. This was the case with five participants who had family members employed elsewhere. On occasional holidays, weekend and leave breaks, the employed family members used to return home to participate in productive activities.

My husband used to come home during weekends, leave and holidays to provide labour in crop and livestock production. Since he fell sick in 2007, his homecoming did not add labour to productive activities (P8)

The indirect effect of sickness on availability labour was experienced by household members who were not sick but cared for and supported their sick family members. Seven (7) participants diverted their labour to care for and support sick household members were asked the probing question *"Can you recall how providing care and support to a sick family member changed your productive activities?"* The caregivers shared their time between being at home, at productive activities, and in some cases, travelling from home. The situations forced them not to attend to productive activities.

My husband, very often, took sick leave from employment and he had to be home during that time. I provided care and support, so I spent more time at home than before. I had to travel from the village with my sick husband to seek treatment. While I did that it meant my labour and his were not available for ploughing, weeding and harvest of our main maize and sorghum crops from 2006 to 2009. (P1).

P2, P3, P6, P7, P8, and P9 had a similar experience to that of P1. They frequently travelled to seek healthcare for their spouses, which reduced their involvement in productive activities.

From July 2007 I travelled away from home with my sick husband and on some occasions, this was for several days and to distant places such as Mutare and Harare. At one point I had to be away for two full months (P1)

Even when the participants were at home and not travelling to distant places, they explained how on each day they had to be readily available to check on sick family members. In the experiences of P1, P2, P3, P6, and P9, this constrained their participation in IGAs. Some participants abandoned entire IGAs because of the pressure from the added care responsibilities.

Kubva pandakashaikirwa nemurume wangu muna 2008, ndakaregedza zvekukuya nekutengesa dovi, nekutengesa mameti nehembe munharaunda

medu. Mabasa emaoko aya aindisunda kuti nguva nenguva ndisava pamba kwemahour akati. Panguva yanga yakanyanya urwere ndaisatombotora mukana wekubva pamusha kana zvemahour mashoma kuti ndive pedyo kupepa murume wangu. (Since my husband died in 2008, I stopped producing and selling peanut butter, buying and selling mats and clothes in local markets. The activities demanded me to be occasionally away from home even for some hours. At the peak of his sickness, I could not even take the chance to leave home for a few hours to be on hand to care for my husband.) (P9)

P6's husband had regular sickness forcing his labour to be unavailable to continue the operations of his IGAs. This was a recurrent pattern for all households that experienced sickness.

Murume wangu aigara achibata zvigwere zvenjovhera achigwara ari pamubhedha nguva dzakawanda. Akamanikidzwa kuvhara mabhizimusi ake aaifambisa paNyika growth point. (My husband regularly contracted STIs and was bedridden most times. He was forced to close the income-generating activities he operated at Nyika growth point.) (P6)

At some point, P1, P6, P7, and P8, had to care for more than one sick family member at the same time. They shared similar sentiments on how this significantly affected their availability for productive activities.

Mugore ra2007, umwe mwanakomana wangu akarwara akapinda muchipatara kwaMutare. Apo akanga ari kupora, murume wangu airwara akabva anyanyisa akapindawo muchipatara. Ndakavapo kupepa varwera vaviri zvinova zvakandimanikidza kusiya kurima zvirimwa nemurivo. Munguva dzakapfuura handina kumbova nenguva yandakarima ndikasakoha. (In 2007, one of my sons got sick and hospitalised in Mutare. As he was recovering, my husband's sickness got worse and he too was hospitalised. I was on hand to care for both and this forced me to abandon all crop and vegetable production activities. I never had such an experience where we planted crops and failed to harvest.) (P1)

The significance of the negative impact of sickness on productivity when a household has more than one sick member was also found in another study in Zimbabwe. In their study Mutambara and Mumaniki (2013:641) found a negative correlation (-0.4) between the number of adult household members that were chronically ill and household productivity.

The reduced availability of labour experienced by other participants was corroborated by one participant who himself was at some point a receiver of care. Each of his hospital visits required that he was accompanied by other family members.

> *When I was sick, my family spent more time caring for me than participating in productive activities. Between the 2006 and 2007 agricultural seasons on each hospital visit, I had at least two members accompanying me, who were supposed to be engaged in agricultural production. (P4)*

The change in the availability of labour associated with HIV related sickness created a chain of other related changes whose effects were seen in productive activities of households. The findings on changes in labour availability corroborate those from Nigeria where Ewung, Ater, & Balogun (2019:29) found households affected by HIV and AIDS having an average labour force participation of 3 persons compared to 4 for those not affected. Ewung et al., (2019:) associated the difference in the labour force participation to productivity between these households.

Reduced number and types of productive activities

The reduced availability of labour meant households had to make adjustments to their productive activities. The most common changes participants shared in their narratives were on the number and types of productive activities.

Eight of the nine participants reduced the number of vegetables and crops, with preference being given to types that had lesser demand for labour.

> *Mugore ra2006, gadheni rangu remurivo raigara riine mhando yezvirimwa zvaiva pamusoro pezvina. Kubva pakatanga kurwara murume wangu zvose izvi zvakadzikisa zvakanyanya zvirimwa zvemughadheni zvekuti mugore ra2008 taingorima mhando imwe yemurivo yaingokwana kudya chete. (In 2006 my*

vegetable garden always had more than four varieties of vegetables. Since my husband's sickness, all this was massively reduced that in 2008 we planted only one type of vegetable that was enough for our consumption.) (P2)

The experience of P2 was similar to that of P1, P3, P6, and P7. P3's reduced from more than five to only two and P6's, from four to one. P2's household used to produce three types of crops and in 2008 was forced to produce maize only as they lost the spouse' labour to sickness. P9's continued growing maize but stopped producing ground-nuts and round-nuts after sickness. In the case of P8 before sickness, they produced slightly more crops than other interviewed households. They used to grow sorghum, ground and round-nuts and sweet potatoes and in 2011, the lack of healthy labour forced them to produce maize only and on a reduced size of land.

Four households shared how they reduced the production of cash crops after considering the labour demands for different crops and their compromised labour. They stopped producing crops that demanded more labour at different stages; production and post-harvest handling. They also considered crops that regularly contributed to food needs for their households.

My household used to produce and earn income from selling surplus maize, sorghum and groundnuts. In 2011, when I and my husband were sick, we decided to only produce maize since our labour was not energetic enough for three crops. Sorghum demands more labour at harvest than maize and cannot be consumed daily. Groundnuts require more labour at weeding, harvest and shelling than other crops and is not consumed daily. (P3)

P5 narrated how sickness forced him to reduce the number of his IGAs. He was not able to operate all his three IGAs as frequently as before sickness. He stopped brick making and installation of fencing as he could not reach out to customers and felt he did not have the energy required for these IGAs.

I used to earn income from brick making, selling sausages and installing wire fencing. From May 2010, I stopped brick making and installing wire fencing as I was not energetic and mobile enough to get customers and perform the required tasks. (P5)

The finding on how HIV related sickness changed labour force participation in households is similar to other studies in Nigeria and Kenya. (Alam and Mahal 2014:9; referring to Mahal, Canning, Odumosu & Okonkwo 2008; Yamane & Jayne 2004; Beegle 2005). The findings also confirm the effects of HIV and AIDS on food security and dietary diversity through the reduction in the types of crops grown. This is related to a study by Palermo, Rawat, Weiser and Kadiyala (2013:4) who found a correlation between food insecurity at the household level and poor dietary diversity with lower mental and physical well-being. Households with low physical wellbeing also had signs of food and nutrition insecurity.

Changes in productivity levels

In all households, a common experience associated with HIV and AIDS-related sickness was the change in the productivity levels of economic activities. The compounded effects of reduced availability of labour and reduced number and types of productivity activities were seen in the levels at which productive activities were operating. The participants were asked, "*What change did you observe that showed you that the level at which your IGAs operated had been reduced by the effects of sickness*?" The responses to this question included lower sales, reduced frequency of restocking IGAs, reduced quantities of goods bought and/or sold, fewer markets served, lower levels of harvests and less frequency in operating the IGAs. The following is what some of the respondents had to say, in this regard:

> *I earned income from buying and selling grocery items that I sourced from Nyika Growth Point or Masvingo. I used to replenish the stock once every week. In 2008, my sickness forced me to reduce my replenishment to once a month as I was no longer fit to travel. I purchased fewer, about a quarter, of the usual wares. (P8)*

P8's experience was similar to the narratives shared by P1, P3, P6, and P9. Other participants used margins of decline in IGA sales and income to demonstrate the changes to levels of operation.

> *After I stopped regularly producing vegetables, my sales were less than half of what I used to get before sickness. (P5)*

P6 narrated how her income from vegetables fell by more than 50% after the effects of HIV and AIDS forced her to spend less time on the IGA. She attempted to overcome the challenge by buying and selling vegetables from a local irrigation scheme instead of her production. She explained how she got the vegetables but still, sickness reduced the frequency she could sell.

> *I was not producing enough vegetables as I had less time for the garden. I bought and sold vegetables from a local irrigation scheme. I recall a week in 2010 when I bought vegetables on a Monday, but I could not sell them for four days because of sickness that kept me at home. I cooked some of the vegetables, but most were bad at the end of the week. In the following week, my condition had improved, and I restarted my enterprise but with less than half of the stock as I no longer had the capital. The business is of perishables; you buy today, and you get more when you sell the same day, otherwise, you lose your capital. (P6)*

Though P3 did not stop selling vegetables, she changed from selling vegetables daily before sickness and selling about once a week after sickness. Six (6) other households shared how after sickness they also irregularly operated their IGAs. Their explanations showed how this was most felt for IGAs that had daily or weekly transactions and sales. They emphasised how before sickness, these activities were operating almost daily.

> *Before my sickness in 2007, I had a flourishing homestead vegetable garden where I could make daily sales. This changed after sickness as I was not coping with the labour demands for watering, weeding and the application of pesticides. I abandoned my vegetables and lost them to pests and the quality was poor for a market that prefers fresh vegetables. (P8)*

P1, P2, P5, P6, and P9, all had the same experiences as P8. The participants impressed that it was not just about the energy to work, but also how much time they could dedicate to the productive activities as they did before sickness.

> *Kurwara kwangu kwakasangana nenguva inonyanya kurimwa maghadheni achipa zvekudya nemari. Chero ndaishanda hangu asi ndaisava nenguva yakafanana nemwaka yainge yapfuura apo ndaisava nehurwere. Ndaigona*

kungoshanda kwehour rimwe chete pamazuva maviri ndichingorima hafu yeghadheni randairima pamwaka iyo ndaive ndisati ndarwara. Munguva dzapfuura ndaishanda kwe mahours maviri pazuva pagadheni rainge rakakura. (My sickness coincided with the peak of homestead gardening as a source of food and income. Though I could work, I was not spending the same amount of time as I did in seasons before the sickness. I did at most one hour every two days and planted half the size of land from past seasons. In the past, I spend two hours per day in a bigger garden.) (P6)

The reduction in the size of productive land used by households is similar to what has been found in other contexts. Masuku et al., (2015:8) found illness and death associated with HIV and AIDS being a driver to the reduction of land used for the production of maize, groundnuts, sweet potatoes, potatoes and cotton in Swaziland.

P1, P4, P7, P8, and P9 used the measure of the number of bags harvested to demonstrate the changes to their productive activities. In all cases, the number of bags declined after the households experienced sickness.

I only had 5 bags to sell, instead of the usual 20. (P8)

In the case of P2 in 2007, 2008 and 2010, they did not sell any maize harvest yet in seasons before sickness, they sold not less than 10 bags of maize. Though P7's household maintained the same level of maize harvest, they lost harvests and income from ground-nuts and round-nuts which they stopped growing.

In the narration of P1, P2, P3, and P8, when sick employed family members died, they experienced double changes to their income. They lost the formal wages and reduced income from the sale of crop harvests, that decline due to reduced availability of productive labour.

Kushaika kwemurume wangu mugore ra2009 zvakava mucherechedzo wekurashikirwa nemavoko pakurima zvinova zvakadzikisa gohwo redu nepakati. Pamwechetezve takarashikigwa nemari yataiwana kubva kubasa kwavaishanda. Asati agwara uye azogwara mari yavaiwana kubasa yaitipa chivimbo chekuva nemari, zvinova zvatakarashikirwa nazvo paakashaya. (The

death of my husband in 2009 meant we lost important productive labour which led to our harvests falling by half. Also, we lost the income we earned from his employment income. Before and during sickness, his wages assured us of predictable income which we lost with his death.) (P8)

The changes in productivity levels experienced by the participants had the overall effect of reducing the income their households earned. The change in income concurrently changed the money available for the participant to meet daily family needs. The reduction in productivity levels observed in this study are similar to what Ewung et al., (2019:28) found in a study in Nigeria were persons affected HIV and AIDS had a productivity of 6,715t on/man day and those not affected had 8,285ton/man day.

Reliance on the sale of assets for income

All households did not ordinarily depend on income from the sale of assets, such as goats, cattle, chickens and farm implements. Rather, they depended on the production and sale of crops and vegetables which after sickness, were not performing well since the reduced labour participation by household members.

In the experiences of P1, P2, P6, P7, and P8, they described how the effects of HIV and AIDS forced them to depend on selling assets to generate income. The main reason given was that regular sources were no longer reliable and they had no other options. They were asked, "*Was the way that you used the assets according to your original plan*?" In all cases, the assets were not meant for that purpose and their sale was considered a last resort. There was a marked decline in the types of assets that members owned after the disposals.

The income my household earned from agriculture was not meeting all healthcare expenses. I was forced, on occasion, to sell goats and chickens. I had no other option except selling the assets. At the end of 2006, I had almost 30 chickens and 8 goats, but by the end of 2010, I was left with only 3 chickens and two goats after I sold-off most. I would have sold the assets for agricultural inputs or my children's education. (P6)

The timing when sickness was experienced by participants affected the choices they could make on raising the required money. When the sickness got serious, this also limited the choices for the households.

> *On one night in June 2008, I was seriously sick. I urgently needed money to pay for transport and health fees at the local hospital. In the morning, I asked my child to go and borrow cash from my neighbour. She did not have any cash on her. I asked her to get someone who could buy my two chickens, as I could not afford to delay my hospital visit. She managed to run around in the village and sold the chickens for me. I had planned to sell the chickens to buy my agricultural inputs for the season. (P7)*

When selling their assets, participants did not get the best value for their assets. Considering the death and life situations they had in their households, they had no option but to take reduced prices on the assets.

> *I sold more than ten chickens and three goats to pay for urgent healthcare and transport fees for my sick husband. In all cases, I never got the market prices that we usually sell the same livestock. I remember in 2009, the price one could sell a hen was $6 but I sold mine for only $3 to the only buyer who had the cash. (P2)*

The experience of selling assets to meet health care expenses found in this research is similar to a case from another study in Zimbabwe. In this study Mbereko et al., (2019:9) found a household that sold their two cows to cover expenses related with health care.

Reliance on external sources of income

In the experiences of six participants, their households used to generate income from their economic initiatives and resources. They shared how they had to rely on external mechanisms as sources of income since the onset of the effects of HIV and AIDS. The disruptions to agricultural labour and demands for caregiving and the resultant reduction in levels of productivity were the drivers behind the change. The absence of any other own source of income, depleted savings and the urgency of the healthcare expenses were the main reasons for taking loans, mostly from friends and relatives.

P2, P6, P7, and P8 recalled how after the effects of HIV and AIDS, they had to depend on financial support from friends and relatives following persistent sickness. They revealed how external support did not come in the early phases of the effects but after relatives observed worsening health conditions and the inability to seek healthcare services.

> *Mumwedzi waFebruary 2008 murume wangu aifanira kupinda muchipatara. Kwemwedzi nehafu takakoniwa kuwana mari yaidiwa. Hanzvadzi yemurume ndiye akazotipa mari anetseka nemamiriro ehurwere nekukoniwa kuwana mari dzaidiwa. (In February 2008, my husband was supposed to be admitted into a hospital. For one and a half months we could not raise the needed cash. My husband's sister provided us with the cash after being concerned by the health condition and our inability to raise the money.) (P2)*

Three households with members who were employed noted the change in the dominance of wage income as a source of income after the effects of HIV and AIDS. They shared that in the past, agricultural production was the major source of income for the households. Wage income continued to be received even when the household members were incapacitated by sickness.

> *Before the effects of HIV and AIDS, agriculture provided most of my household's income. After the loss of agricultural income due to the effects of HIV and AIDS, the solace was my husband's employment wage which became the major source of income. (P1)*

The change experienced by P1 was the same as that of P3 and P7, who had their spouses employed before they experienced the effects of HIV and AIDS. All households revealed the gap they experienced on household income after the death of their spouses and the cessation of wage income.

> *My husband's death in 2011 meant we lost our major source of income for the household and we had difficulties getting income from any other source. (P3)*

P5, P6, P7, P8, and P9 referred to the times they regarded taking debt as a source of income. This was because they regularly relied on taking loans to meet their family needs. In the absence of the loans, participants would not be able to pay for their needs.

I had occasions, at times monthly, when my husband and I were sick and desperately needed money. We resorted to borrowing from friends and relatives. At times we got the money but not necessarily what we wanted, or were given terms that were not friendly. (P8)

The participants, whose households relied on loans as a source of income expressed how this was not an easy and pleasant experience. In seeking support from friends and relatives, there was a mixture of feelings. This included the fear of developing the bad reputation of being defaulters in their social networks.

Taking loans from friends and relatives was not easy, even from people close to me. Cash is not easy to come by in rural areas for everyone and you will know that you are only adding a burden to them. So, my running around did not always raise the cash that I needed. I was also afraid that if I borrowed, I would not be able to repay. I did not want to be indebted and have a bad reputation with my friends and relatives. (P9)

The experiences of P9 resonated with that of P1, P3, P6, and P7, which had periods they took loans from friends and relatives. There was a shared sense that by always borrowing, they were becoming a burden to their friends and relatives.

In expressing the extent to which income-earning had been disrupted and reached dire levels, one participant described that they associated the generation of income from begging to the effects of HIV and AIDS. This occurred when the participant lost her spouse and she was seriously sick and bed-ridden.

I became a known beggar of money and food in my village. I was not proud of that but that was how bad my income-earning situation had reached. (P8)

Two participants shared their experiences of relying on piece work as a source income. They provided their labour to other families in return for payments. The reduction of income from regular sources was the main factor in pushing households to rely on piece work.

Kuderera kwemari yaibva mukurima uye nekuwanda kwakanga kwoita mari dzekubhadhara zvehurwere zvakandimanikidza kutsvaka maricho. Ndakanga ndachiita zvemaricho chero zvaipa marishoma asi zvaivanane nokuti zvaitombondipa chokubata uye chaingodiwa maoko angu. (The reduction in income from agriculture and increasing healthcare expenses forced me to seek piecework. I participated in paid piece work though it did not pay much, at least it contributed something and the only input required was my labour.) (P2)

The types of piece-work varied between participants, but included working at homesteads and crop fields. The willingness to take any type of work indicates the limited options that participants had to generate income from regular sources.

I engaged in any paid piece-work whenever there was an opportunity. This included weeding gardens and crop fields, harvesting crops and fetching firewood. (P6)

They were probed on "*Why do you particularly mention relying on piecework as a change to how your household generated income*?" A thread shared by the two households, related to how piecework is usually associated with mostly poor households that cannot be productive on their own. They explained that piecework was viewed as a last resort means of generating income if one had failed to engage in other types of self-managed activities.

If I had the capital and viable options for generating income, I would not have participated in piecework. (P6)

Weinhardt et al., (2017:719) found households in Malawi practising piecework (locally called *ganyu*), but with less occurrence among treatment households involved in savings groups and other services than the control group. This variation from the findings confirms that in the presence of other options, piecework is not a preferred option. In Sudan borrowing was also found as a coping strategy adopted by persons affected by HIV and AIDS when their income changed (Ismail, Kari and Kamarulzaman 2017:453).

b. Effects of HIV and AIDS on household income spending

After energy, sickness in this study is triggered to an individual's experience one of the components of their story becomes an action (Bruner, cited in Brown,2017:218). The action being the participant's response to the energy. In this study, the action is specific to the economic spending related decisions and choices that participants took. The changes households experienced in the generation of income influenced adjustments on how income was spent. From the experiences shared by the participants, the pressure from healthcare expenses was the major force to households changing their prioritisation of usual expenses.

Dominance of healthcare spending over other needs

The onset of the effects of HIV and AIDS was associated with expenses for healthcare and food having high priority. This was followed by transportation expenses to health facilities. Education, clothing and agricultural inputs received lower priority. The reduced capacity to produce food forced some households to rely on food purchases. The more frequent reliance on loans led some households to regard debt repayments as part of regular household spending. Some households introduced expenses for paid labour in agricultural production and childcare, because of compromised labour and health-seeking behaviour.

Across all households, a major theme was that healthcare expenditure became a priority above all other expenses, which was not the case before the effects of HIV and AIDS. They were asked, "*Why did you make these changes to your household spending priorities*?" Restoring the wellbeing of sick family members was considered important in regaining the productive labour for households and reversing the negative economic effects of HIV and AIDS.

> *In the past, when I prepared my household budget, it had food and my children's education as priorities. Since the effects of HIV and AIDS, this changed to health and food first, and then education came after. The first two would keep adults working and providing for the family. (P9)*

This change was like all other seven households, except P5, that had no children enrolled in school when they started experiencing the effects of HIV and AIDS. Five participants, revealed a pattern of how initially healthcare expenses were not regular but ad hoc, as they responded to symptomatic sicknesses. This changed to more regular spending as they dealt with opportunistic sicknesses and known health conditions. They bought treatment for symptomatic

sicknesses such as headaches and coughs. The remedies were mostly local and based on knowledge of how such sicknesses were usually managed, without examination by professional health providers. The members were asked, "*Why did you prefer not to use professional health service providers?"* They viewed the local remedies as affordable and the expense as insignificant to affect overall household expenditure. However, they all acknowledged that they later realised that the cumulative small expenses had a substantial effect on the pattern of household spending and their ability to meet other expenses.

> *In the early stages of sickness, for 6 months, my husband did not want to go to a hospital. Yet still, we regularly spent money at local shops on medicines for pain, coughs, colds and indigestion. On reflection in that period, I spent more money on healthcare than I had since I got married. The amount for each transaction was small yet when I added them it was a lot of money that I could have used for other daily needs or specialised healthcare. (P1)*

P2 revealed how spending could be very frequent over a short period. This was mainly because the local remedies they bought did not treat the conditions. The frequent and incremental small healthcare spending changed the ability of participants to pay for other family needs.

> *Taidzokorora, zvimwe pazuva rega-rega, kutenga mapiritsi ekudzisa marwadzo, mishonga yefulu nechikosoro zvaingoderedza hurwere kumurume wangu. Kurwadziwa kana kukosora kwaingomira kwemazuva mashomana chete. Ndavakutarira kwatakabva takashandisa mari yakawanda asi ichibuda zvishoma nezvishoma. (We repeatedly, even daily, bought painkillers, cold and cough syrups that only provided temporary relief to my husband. The pain or a cough could stop for a few days only. As I reflect, we spent a lot of money but in small amounts.) (P2)*

The experience of P1 and P2 with spending on local remedies for symptomatic sicknesses, was similar to that of P5, P7, and P8. The common knowledge of remedies for such sickness was relied upon in making the spending decisions.

The diagnosis of the nature of sickness and the willingness of sick household members to enrol on treatment raised the level and regularity of household spending on healthcare. This was the experience of all the household members.

> *In 2008 the deteriorating health condition of my husband had him take an HIV test. This added new and regular expenditure on ART, hospital visits and buying some medicines. Healthcare expenses became a regular priority above all. When we had the cash, the first expense we planned for was healthcare. (P1)*

The drop-out of children from school was reported as a major mark in the downgrading of education expenses. This was experienced as a demonstration of the inadequacy of income because of increasing healthcare costs.

> *Mari dzataishandisa kuhurwere dzakatimanikidza kutanga kunonoka kubhadhara mari dzelevy yevana kuchikoro. Pamusoro pemalevy paiva nezvimwe zvaida kubhadharwa semabhuku nezvinyoreso, hembe, chikafu nemitambo inoitwa chikoro. Vana vaidzingwa chikoro patemu yoga-yoga muna2011 na2012 nekuda kwekusabhadhara mari dzemafees. Mumagumo azvo kuvabvisa kuchikoro ndoyakatozova nzira yatakatora kusvika kupera kwa2013. (Healthcare expenses forced us to start delaying paying children's school levies. Also, in addition to the school levies, there were other expenses such as school stationery, uniforms, food and activities that we could no longer afford. My children were sent away from school almost every term in 2011 and 2012 because of the non-payment of fees. Ultimately, withdrawing them from school was a measure we took until the end of 2013.) (P3)*

Three participants expressed how they considered the effects of sick adults on the well-being of children and their performance at school. They revealed how living with sick parents negatively affected children. They would rather prioritise the recovery of adults to save children from the negative effects.

> *My sickness negatively affected my children's performance in school as they would be worried and went to school late or did not go at all as they played a role in caregiving. I diverted any money we had to healthcare expenses to save*

them the pain and labour of seeing me sick. In 2010, the children missed two school terms for non-payment of fees. I did not see the value of forcing them to go to school and my further accumulating debt, so I withdrew them in 2010. (P6)

Participants P8 and P9 had the same experiences as P6, of forcing children to drop out of school. P8's fear of destitution and having children begging at school led to the decision being made.

Starting 2008, I could not afford to provide the educational needs of my three children. They were now known as street kids in the village because instead of going to school they were begging. I had to drop them out of school until 2013. (P8)

Salwa et al., (2017) had similar findings in Sudan where the main reason children were withdrawn from school was the inability of households to afford the costs of schooling. This was because the households lacked income.

Three participants, P1, P7, and P9 described how they stopped buying clothes for family members since the onset of the effects of HIV and AIDS. This was against a background where such expenditure could be made whenever they wanted.

Between the years 2007 and 2011, I had to forego expenditure on clothing as I could not afford these. Before the effects of HIV and AIDS, I bought clothing for the family when I wanted to. (P1)

Healthcare expenses were reported to have been prioritised ahead of household savings. Households that had savings for productive purposes reported having diverted these for healthcare expenses. The members were asked, *"Why did you use savings for a productive purpose for healthcare expenses?"* The availability of substitute agricultural inputs, even of poor quality, was a reasonable justification for the diversion of the savings.

I withdrew a substantial part of my household savings for healthcare expenses. This was money I had set aside for buying agricultural inputs. I knew I could

use substitute inputs, but I could not take chances with a family member's sickness. (P9)

The experience was shared by P1, P2, P6 and P8. Though the savings had been set aside for other uses such as housing improvement, education and assets. In Zimbabwe study by Mbereko et al., (2019:9) found a household that had been forced to withdraw their savings to pay costs associated with seeking health care. This is similar experience that the participants shared in Bikita.

Participants shared how healthcare expenses forced them to change their spending on non-consumption needs, such as household display and hair products. The participants were asked, *"Was reducing expenditure not a difficult decision*?" Of the concerned four participants, they revealed that taking the decision was not difficult. They did not see the value of these expenses in restoring the wellbeing of sick household members.

Muvillage mune vanhu vanotengesa zvinhu zvakango siyana-siyana zvekushongedza uye ini ndaisiva mutengi nguva zhinji. Zvaitengeswa zvino sanganisa zvekushongedza mumba nezvizorwa. Ndakarega kutenga zvinhu izvi sezvo zvaisabatsira kupedza dambudziko rehurwere. Handina kushungurudzika nedanho randakatora. (In the village, we had people who sold different luxury goods and I used to be a regular buyer. Such goods included house display items and cosmetics. I cut this expenditure as it did not help the sickness we had. I did not feel bad about the decision.) (P3)

P1, P6, and P8 shared a similar experience. The experience of P6 was unique, as it revealed the effects on their participation and contributions to the church.

I recall a day in 2009 when I needed cash for my weekly church offerings. On this day, I had $50 left in the house and the previous week we had spent $30 on healthcare expenses. I asked myself what if in weeks ahead I had to spend the same amount. I decided not to make offerings to the church, something I had not done since being a youth. (P6)

The findings from study confirm the pressure and changes that sickness causes on household spending decisions. Expenses that do not directly or indirectly support the recovery of sick household members are not prioritised. A study in Bikita district similarly associates financial constraints with the inability to pay for food, clothing and shelter by persons affected by HIV and AIDS (Zvinavashe et al., 2015:3). The inadequacy of income for adults living with HIV and AIDS to meet these same needs was also associated with sickness from a study in Jos state of Nigeria by Adamba and Nwankwo (2019:28).

Changes in the use of agricultural inputs

HIV and AIDS was associated with reduced use of improved agricultural inputs, as households could not afford them from the point they started experiencing sickness. To cope with economic shocks, most households used seed reserved from the previous season's harvest or used fewer improved inputs than in the past. The change had subsequent effects on levels of harvests and income earned from the sale of crops.

8 participants used poor quality agricultural inputs for crop production, because of the effects of HIV and AIDS. They were asked "*Why did you have to use poor quality inputs and what types were they*? Limited financial resources were the main reason that led the households to take the decision. Financial resources were reported to have been diverted to healthcare services, and they could not afford any or limited improved seed varieties and fertilizers. Instead, they planted seed reserved from past seasons and did not apply all or one of the fertilizers. The households had experienced high crop yields when they used improved seed varieties and applied top and bottom dressing fertilizers. The changes made after sickness led to a decline in crop harvests and the availability of surplus to sell.

> *My household used to plant improved seed varieties for maize, sorghum and groundnuts and annually, we always had a surplus to sell. From 2007, when my household had sickness, we planted seed reserved from previous seasons' and our harvests were very low. (P7)*

The experiences of P2 was similar to that of P1, P3, P6 and P7. The experience of P6 illustrates the risk associated with the use of seed reserves from past harvests if users lack the knowledge on how to preserve them.

My household failed to buy maize seed for the 2009 planting season. I did not have the money, as I had spent all the financial resources on health needs. We planted maize reserved from the past harvest. Unfortunately, we did not know that there was a special way that the maize must have been selected and reserved to make it better substitute seed. The harvest was so low that we had only about 12 bags from our usual more than 30. (P6)

Before the effects of HIV and AIDS, eight participants revealed how they bought improved agricultural inputs, particularly crop seed and fertilizers. They understood their value in increasing crop yields.

Pamwaka yainge yapfuura, tisatitava nedambudziko rehurwere taitenga mbeu dzakanaka dzechibage nemhunga zvaitipavo gwohwo rakanaka. Pakati pa2008 na2010 hatina kumbotenga mbeu yakanaka sezvo taichengetedza mari kuitira hurwere. (In seasons before sickness, we always bought improved seeds for maize and sorghum which gave us good harvests. Between 2008 and 2010, we did not buy any improved seeds as we reserved all the money for healthcare expenses.) (P2)

P4 was a regular user of chemical fertilizers, before the economic effects of sickness. Since her household had a sickness, they could not afford these and had to resort solely to the use of cow dung.

Before sickness, my family always bought and used both the bottom and topdressing chemical fertilizers in crop production. From the 2005 agricultural season, after my sickness, it became a challenge for my family to afford the fertilizers as we prioritised my healthcare needs. The cow dung from our kraal became the only application we made to improve our soils. Unfortunately, since this change our harvests were always below those we had before sickness. (P2).

In Swaziland, Masuku et al., (2015) found similar impacts of sickness related to HIV and AIDS on the use of agriculture inputs in crop production. In the study they found persons affected by

HIV and AIDS experiencing between 2.3% to 6.3% decline in the use of seeds, fertiliser and chemicals in the production of crops.

Increased spending on transportation

Earlier and in this part, the findings illustrate the importance of location settings in storytelling (Moezzi et al., 2017). The specific location of the participant, the sick family members and other family members bring out the different dimensions of experience on the influence of sickness on household spending. In some instances, the specific location of the participant changed, which in turn is used to illustrate either the burden or the intensity of change in the experience.

The experience shared by all participants illustrated the challenges that rural households face in accessing healthcare services, where there are limited facilities. They described how accessing healthcare services required regular travel, which added unplanned and unfamiliar transportation expenses for their households. P1, P2, P3 and P9 referred to one-way distances between their rural residences and cities of Bulawayo, Harare and Mutare. These are all more than 220 kilometres away. The high frequency of travel to these locations was used to indicate the level of expenses they incurred as part of caring for sick family members.

> *In the period that my husband was admitted in a hospital in Mutare and Harare, I made frequent visits from my rural home. Over two years in a month, I could make 6 long-distance travels to either place. Transport fares were a new and unusual expense that I prioritised with healthcare. (P1)*

The experiences of P1 was the same as that of P2, P3 and P9. The change from usual location to another did not stop, but added expenses they experienced even if they lived with the family. In addition to transport expenses, the travel to the cities required the households to pay for some up-keep expenses.

> *Chero ndaigara nemwana wangu pandaienda kuHarare ndaizozvibhadharirawo zvimwe zvaidiwa semari yezvifambiso nezvekudya ndichienda kuchipatara. (Though I lived with my child in Harare I paid for living expenses such as daily transport to and from the hospital and food.) (P2)*

Aside from demonstrating the role of location in storytelling, this experience brings out the role and limits of social capital. While participants used their social networks of family and friends to access accommodation and utilities, they could not provide for transportation and food. The participants paid for these expenses.

Six participants who sought medical care from health facilities within the district revealed that they also spent on transportation. This was because their places of residence were beyond walking distance.

> *Munguva dzapfuura pasati pava nehurwere pashoma pandaiita nzendo kuzhe kwekuti ndichifambira zvamabhindauko. Asi pandakava pachirongwa chekurapwa zvakawedzera zvitsva zvekushandisa mari pazvifambiso kuenda kuchipatara kunoongororwa nekurapwa. Ndinoda madhora mana parwendo rumwe kunoongororwa nekuitwa CD4 count. Iyi imari yandinoshandisa nguva nenguva inova yandinorongera kuisa padivi. (Before sickness, I rarely travelled for any other need besides doing business. Being on ART added new transport expenses for visits to health facilities for tests and treatment. I need $4 for a single trip for reviews and CD4 count check. This is a regular expense for which I set aside some money monthly.) (P7)*

The experience of P7 was shared by P6, P2, P4, P7, P8 and P9. The local transportation expenses were not easy to raise for the households.

> *Each hospital trip required $10. That was difficult to raise as I had no regular source of income. (P6)*

The challenges of meeting transport expenses to seek healthcare services by HIV and AIDS affected households concurs with those from a study of adolescents and young adults in Uganda by Nakigozi, Makumbi, Kigozi, Nalugoda, Reynolds, Chang, Kagaayi, Serwadda, Wawer and Gray (2015). The effects of long-distance and high transport costs are noted to have negatively affected enrolment into care programmes (Nakigozi et al.,2015:108).

Change in sources of food

The participants described the changes their households made on spending for food since they experienced the effects of sickness. Four participants revealed how before the effects of sickness, their households combined consuming largely what they produced and occasionally making purchases of select food commodities from local markets.

> *Before sickness, the food my household consumed was what we produced in our crop fields and the vegetable garden. The lack of labour and attention led to reduced productivity. We started spending more on food that we bought from the local market than before sickness. (P1)*

Two participants, P8 and P9, described a similar experience as P1 on food purchases from the market. In households where income was declining, this meant the quantity and quality of food available to the households also changed.

> *I could not produce enough vegetables to meet my household's consumption because of the effects of sickness. I bought vegetables from the market. I had to spare and spent more money on food than before sickness. Yet I could only buy smaller quantities and types. (P8)*

Food purchases were explained as an additional expenditure, despite the importance of the wellbeing of humans. The spending strained households already burdened by healthcare expenses.

> *The vegetables I bought added financial burden to what we already spend on health care expenses. (P9)*

The participants were asked, "*Why did you have to resort to food purchases if this was straining your household*?" They were motivated by health and nutrition knowledge gained from support groups on the importance of food consumption when on treatment.

> *Chakakosha chandakadzidza kuSupport Group chaiva chekuti ukadya zvakanaka uye uchimwa mushonga unova nemukana urinane wekuva nehutano hwakanaka. Saka ndaitotenga zvekudya apo ndaisakwanisa*

kuzvirimira (An important lesson from my support group was that when you eat well and take treatment, you have better chances for good health. So, I had to buy food when I could not produce my own.) (P8)

While P8 and other participants increased market food purchases, the experience was different for some. There were participants who shared how their situation changed after the effects of sickness. Sickness introduced healthcare expenses that resulted in the participants not being able to afford food purchases from the local markets.

Before the effects of sickness, I used to always buy food items such as meat, rice, and margarine. As the year 2007 went by and my husband's health condition worsened, and we started to forego and reduce expenditure on these items. We consumed mostly what we grew. (P2)

The participants were asked, "*Why did you reduce your spending on food?"* A few of the members revealed that this was to spare any cash they had for healthcare expenses.

Nekuda kwemamiriro azvakanga zvakaita taitenga zvokudya zvishoma pamisika yemuno. Mafambiro aiita mari ainge adzika uye asinga zvivikanwi saka taingoisa padivi chero mari yataiwana kuitira kubhadhara zveurwere. Takanga toshandisa mari yakawanda kune zvehutano munedzimwe nguva, kunyanya muna2010 na2011 zvaitoda kushandisirwa mari svondo rega-rega. (Out of circumstances, we bought less food from local markets. Our cash flow was reduced and unpredictable, so we had to set aside any cash for healthcare expenses. We were spending more on healthcare and at times, especially in 2010 and 2011, these were weekly expenses.) (P3)

P4, P8 and P9 recalled that they continued making some food purchases. They were probed on "*Did you continue buying the same food items you bought before the effects of HIV and AIDS?"* All three described how they looked for cheaper substitutes to save as much cash as they could.

Balancing between expenditure for food and health was a big challenge, between 2007 and 2010. We could not afford to spend the same amount of

money on food as before. We bought cheaper substitutes for cooking oil, baking flour and beans to save for healthcare. (P4)

The findings from this study show how households shifted between relying on food from market purchases and own production to cope with the effects of sickness. The changes that households made to sources of food are not prominently featured in other studies that focus on copings strategies in response to the effects of sickness on food security. In a study in West Bengal the food security related coping strategies that households experiencing sickness adopted included taking loans in the form of money and food, selling produce or assets and support from family members (Dasgupta, Bhattacherjee and Das 2016:245). These coping methods are similar to what was found being practiced during food shortages by Pienaar et al., (2017:128) in a study of rural and urban households in the Free State Province of South Africa.

Repayment of debts as a regular household expense

Repetitive reliance on loans to meet daily expenses can force households to regard repayment of the debt as part of regular monthly budgets. This can create challenges for households, particularly when their productivity is constrained as those affected by HIV and AIDs. Five participants revealed how they regarded repayment of debts as part of household expenses. The households regularly took loans to pay for healthcare expenses.

In 2008, my mother-in-law and I were sick. I regularly took loans from friends to pay for healthcare needs. Until 2010, I included paying back in the family budget. (P6)

P5, P7, P8 and P9, shared a similar experience where loans became the dominant source of cash to meet daily needs. Spending on debt was not a regular financial obligation before the effects of HIV and AIDS.

I reached a point in 2007, where every month I had to take a loan to meet daily needs from friends or relatives. Each month I had to find a way to repay the loans to keep my chances of getting the next loan. (P7)

P5 referred to how his borrowing rate from friends and relatives led to stigma. He believed that the only reference that people in the community could make about him was the frequency of borrowing.

> *If you walk in the village and asked what people knew about me in 2012, I am sure they will mention "borrowing". My situation had reached that level, where I had a loan with almost every person that I regarded as a friend. I was not proud of it, but I had no other option but to live with the identity my circumstance created. (P5)*

The experience of P5 points to how even when social capital brings support it can also leave negative results on the recipients. However, the difficult circumstances of the recipients forced them to disregard or live with negative feelings.

Addition of hired labour to household expenses

Another change experienced by some households after sickness was the addition of paid labour as a household expense. This was a response to some of the incapacities and constraints arising from sickness. Participants revealed how sickness forced them to incur expenses for childcare labour and productive activities. P8 explained how she hired labour to care for her children when she made visits to health facilities. The children aged 10 years and below were too young to be left at home without adult care.

> *I paid someone to take care of my children when I made hospital visits. As my income declined, I could not afford this all the time. On one such occasion, in 2011 I left my children (aged 7 and 10 years) on their own, without an adult caregiver for three days. (P8)*

Four participants: P1, P3, P8, and P9 responded to the loss of household labour by hiring paid labour as an input in agricultural production. They explained how this added a production cost that they did not have before the effects of HIV and AIDS. They were asked, "*Why did you have to hire paid labour?"* This was an effort to continue to be productive and ensure the households harvested enough to meet their food needs.

Kugwara kwangu kwakasvika mumwedzi waOctober mugore ra2012 panova ndopatinotanga kugadzirira minda yekurima zvirimwa. Sezvo ndakanga ndisina maoko akakwana uye ndisingakwanisi kuita mamwe mabasa, sekudyara mbeu, ndakatsvaka munhu wekubatsira wandaibhadhara. Ndakanga ndisina kugadzirira mari dzacho dzaikwana saka ndakarima padoko zvakasiyana nemwaka yainge yapfuura. Chero gohwo redu raiva pasi pemwaka yainge yapfuura, takangowana zvaikwana kuti mhuri idye. (My sickness extended to October of 2012 when we were to start our land preparations for crop production. As I was handicapped and no longer able to perform some tasks, such as planting, I hired paid labour. I was not financially prepared for this input, so I planted a smaller piece of land than past seasons. Though our harvest did not match the levels of previous seasons, we had enough to feed the family.) (P9)

In the case of P3, the hiring of paid labour was the only option for her household expecting a harvest. If they did not take that option, their families risked being food insecure.

I was sick, and the only other labour in my family was my young children who could not be involved in agricultural activities. I hired two local people to assist with both ploughing and planting of maize. If I had not done so, we were not going to plant and harvest anything in 2012. (P3)

These findings on the use of paid labour have also been experienced by households affected by HIV and AIDS in the northern part of Zimbabwe from a study by Mbereko et al., (2019). In this study the researchers found two households that could afford to pay for labour that provided care and participated in productive activities.

4.3.2. How ISAL changed the way persons affected by HIV and AIDS generated and spend income

The second part of personal truths is the experiences of participants that lead them to identify what is right (Brown, 2017: 218). The positive experience that was generated, was the importance of ISAL to the wellbeing of participants. This is shown in many dimensions, including restoring and increasing income earning, increased and sustained the ability to spend. To bring the vividness of the right change, participants often expressed this by going

back to the past and recalling the bad experience of being sick and not having the means to pay for health care. The findings show that ISAL positively supported both income generation and spending for all the participants. The opportunity to access loans and lump sum savings allowed for investing in income-generating activities that restored and improved the frequency and levels of income and what households could spend on. Areas of spending that had been negatively affected by HIV and AIDS were largely restored and households could afford additional daily expenses.

c. Effects of ISAL on household income generation

The limited external support, the desire to restore disrupted productive activities and income earning, the aspiration to meet own livelihood needs and have household savings and the healthcare burden on-hand, were mentioned by the participants as the motivation to participate in ISAL. All of them expressed a commitment to pursue opportunities to change their circumstances and being able to generate own income. This sense of individual agency and power for self-help to improve their lives is a core indicator of empowerment in the economic empowerment theory (Turner & Maschi, 2015:158). All participants noted positive change and achievement of individual objectives that can only be associated with their membership and collaboration in support groups. Though Huxham and Vangen (2013:4) refer to collaborative advantage theory at an organisational level, the attributes they include apply to relations between individuals. They argue that the two parties collaborate when they are not able to meet their objectives using own resources (Huxham & Vangen 2013:5).

Changes to the operations of income-generating activities

Participants described how their households used ISAL financial services, loans and share-out payments to operate IGAs. The participants were asked, "*Did you already operate the IGAs before sickness?*" All nine participants explained that they had used loans from ISAL to restart IGAs whose operations had been disrupted by the effects of HIV and AIDS. In South Africa, households affected by HIV and AIDS participating in ISAL also appreciated the opportunity to access loans from groups (Barber, 2011:22). They were further probed on "*Why did you choose to restart these activities?*" They narrated how it was easy to restart the IGAs once they had capital, as they already had the skills, knowledge and experience to operate the activities, had links of where and how to source inputs and sell. They revealed how they did not want to take risks with new IGAs that could delay their earning the much-needed income.

In 2010 the effects of HIV and AIDS forced me to stop operating my broiler chicken production. In 2013, my group gave me a loan of $25 that I combined with my pension pay-out to buy 25-day old chicks, feeds and vaccines. I had the skills and knew places where to sell since I operated the same activity with 50 birds for more than 3 years before the effects of HIV and AIDS. I have since increased to 75 birds at any given point. To this day, this IGA is contributing substantially to my household income. (P1)

The other eight participants also reported using their first loans from ISAL for IGAs they were familiar with. The risk of failure and pressing household well-being needs were expressed as the main drivers for avoiding the risk of investing in new IGAs.

P1, P6, P8 and P9 shared how they used ISAL loans to restore at least two IGAs that they operated before the effects of HIV and AIDS. This allowed them to spread their risk and improve their cash-flow.

On my first savings meeting, I got a $20 loan. That was enough to buy my ingredients for traditional beer brewing and selling activity that I operated before the effects of HIV and AIDS. I used part of that loan to restart a homestead vegetable garden I had in the past. Before the next month's meeting, I had brewed and sold traditional beer three times and planted three varieties of vegetables. I repaid my first loan without a problem. After two months, both activities became regular sources of income. (P9)

The experience of P9 was similar to that of P1, P6, and P8, though they operated different types of IGAs. A noted trend was that most participants used the loans to choose those activities they were involved in before sickness. All the participants reported that ISAL loans had enabled them to restore income-earning to the levels before the effects of pre-HIV and AIDS. P1, P3, P5 and P7 revealed how the income they were earning surpassed what they used to earn before the effects of HIV and AIDS.

In the fourth month, I was one of the few members that got a loan of $150, which I used to travel to South Africa to buy wares for resale. In a week, I was back and started selling. At the end of the first week, I sold all I had, and I travelled

back to South Africa. I returned in time for our next group meeting where I repaid my loan. I earn a better income than the level before the onset of my sickness. (P7)

P2 and P3 shared a similar experience with the loans they received for restarting their fish buying and selling and vegetable production IGAs, respectively. In addition to restarting the IGAs, both members indicated that ISAL loans improved the frequency they handled cash.

Ndakatora zvikwereti zvitatu kusimudzira bhizimusi rangu rekutenga nekutengesa hove. Panguva yekugwara ndaiita masvondo akati kuti kana mwedzi ndisina kuwana mari. Kubva pandashandisa zvikwereti nguva nenguva ndinowana mari uye ndinotengesa pazuva rega-rega. (I took out three loans to revive my business of buying and selling fish. During sickness, I could go for weeks or even months without having income. Since I used the loans, I regularly earn income and I usually make daily sales.) (P2)

Four participants described how their households used ISAL financial services to start-up IGAs they had not operated before. They revealed how, when there were surplus savings, their groups allowed them to access repeat loans. They were asked, "*Why did you decide to start new IGAs?"* The participants explained how multiple IGAs increased their incomes and assured the stability of cash flow in case one IGA had challenges.

I needed to operate more IGAs to make-up for the loss of my husband's wage and increase my income. In 2013 I received a second loan of $50 that I used to buy clothes for resale which I had not done before. In a few months, this was contributing to regular, weekly, income for my household. With this and my poultry and vegetable production, my household always has access to cash. (P1)

P2, P3, P4, P5 and P8 had the same experience of starting-up new IGAs. In the case of P2, the household experienced an increase in the performance of the new IGA since its start-up. Similarly, in Malawi, a study by Weinhardt, Galvao, Yan, Stevens, Mwenyekonde, Ngui, Emer, Grande, Mkandawire-Valhmu and Watkins (2017:716) found 55.8% of the participants

vulnerable to HIV and AIDS reporting that loans from savings groups (Village Savings and Loans Associations) helped them to start their businesses.

> *I used my third loan to buy 1 (one) box of washing soap and 10 packets of sugar for resale. This was a new IGA that I wanted to compliment my other activities and give myself the chance to regularly have cash in the household. I now sell 5 boxes of soap and 20 packets of sugar each month. (P2)*

P4 described how they used their loans as a new way of earning income. The member took loans from the group that they further on-lend to non-group members with an additional margin on the interest rate.

> *Ini handioni saka mikana yemabasa emaoko andinogona kuita mishoma. Ndaitora zvikwereti kubva kuboka ndonokweretesavo vamwe varimumaraini edu asi vasiri muboka redu. Ini ndaivati vadzose chikwereti ne25% yaiva pamusoro peyekubereka yaidiwa ye20%. Saka ini ndaisara ndiine chikamu che5% semari yandinenge ndawanavo. (I am visually impaired, so I am limited on the types of IGAs I can operate. I got loans from my group that I on-lend to other community members who are not part of my group. I on-lend at a rate of 25% that is higher than 20% of the group charges. I retain the 5% margin as my income.) (P4)*

P5 used an ISAL loan to buy an asset, solar lighting kit, to improve lighting in his household. He described how an additional function, phone charging, on the kit became a new income-earning opportunity.

> *I bought a solar kit that I used to provide lighting for the family. The kit has a facility to charge cell-phones. I took this as an opportunity to earn income. I have customers that bring their phones for charging, at a fee of $0.50. This gives my family a daily income. (P5)*

Participants described how they accessed multiple loans for the same IGAs and this increased their production and income-earning capacity. P1, P3, P5, H6, P7and P9 who produced vegetables used multiple loans to increase the diversity of vegetables they grew and sold.

> *In my second meeting after joining the group, I got a loan of $20. I used this to buy seedlings for my homestead garden. In another ISAL meeting, I took another loan of $10 to buy more and other types of seedlings. By the third month, the response from customers was overwhelming as I made sales every day of the week. (P6)*

P1, P2, P3, and P7 described how they used ISAL to restore the capacity of IGAs. The activities were still operating, but below the capacity of the period before the effects of HIV and AIDS.

> *Before and during the effects of HIV and AIDS, I produced and sold vegetables and peanut butter, I also bought and sold mats and clothes. I took seven loans at different times to restore the operating capacity of all three. They generated income at levels they used to before the effects of HIV and AIDS. (P7)*

The changes that ISAL caused to the financial capacity of persons affected by HIV and AIDS in this study resonate with findings from the other contexts. In Malawi members of village savings and loan groups shared experience of how their households were able to operate diversified IGAs (Sears, Andersson and Canna 2016:618). The expansion of IGAs observed from this study is similar to that of microfinance clients in Uganda. According to Linnemayr, Buzaalirwa, Balya and Wagner (2017:258), clients that received loans in rural Soroti in Eastern Uganda were found to have used them to expand their IGAs.

Restoring diversity in agricultural production

Crop production is the predominant economic activity and source of income for households in Bikita. The experiences shared by all participants confirm the support that ISAL had on this economic sector. Earlier findings from the participants showed that HIV and AIDs negatively affected crop production by reducing the number of vegetables, crops and even the size of the land on which they produced. Access to loans restored the diversification in agricultural production. This was associated with an increased surplus harvest that was sold for income. The experience of P3 was shared by all six other participants.

Mugore ra2013 na2014 ndakatora zvikwereti zvakakwana kuti nditenga mbeu nhatu dzezvirimwa. Uye ndakatoravo zvimwe zvikwereti ndichitenga maseeds emurivo nematomatisi zvemugarden. Kubva ipapo kusvika nhasi ndorima zvirimwa zvakasiyana siyana kumunda zvose nokugarden. Uye ndima yandairima ndisati ndavanehugwere ndoyandava kurima. Zvekutengesa zvinobva zvawandavo. (In 2013 and 2014, I got loans that were enough to buy seeds for three crops. Also, I got other loans to buy garden seedlings for leafy vegetables and tomatoes. Since then to date, I grow different types of crops in my field and the garden. I now plant crops on the same size of land as before sickness. There will be plenty for me to sell.) (P3)

Participants shared how the diversification in crops and vegetables supported by ISAL helped them to cope with the unpredictable weather patterns. They could plant different crops and vegetables at different points during and after the rain season. They believed that doing so gave them better chances for thriving in their agricultural activities.

Since 2011, when I participated in ISAL I have taken various loans to buy crop and vegetable inputs that I plant at different times. I mix between short and long season varieties and some that I grow by watering. The rainfall pattern is not very predictable these days so when I have different varieties of inputs it improves my chances of being assured of getting average to very good harvests, which I can attest to. (P6)

The loans from ISAL were associated with the end of using agricultural seeds reserved from previous harvests, which four participants associated with low harvests. The use of reserved seed was associated with high use of labour yet yielding low harvests.

Ndakanga ndaneta nesimba randaiisa pakurima mbeu yekuuchika. Ini ndadero ndaingowana mukohwo wakaderera. Zvemukando zvakandibatsira chose. Muna2013 ndakatora chikwereti chekutenga ma10 kg maviri embeu yechibage. Ndopakaperera kushandisa mbeu yekuuchika. (I was tired of the energy I was using planting seeds reserved from a past harvest. After doing that, I would get low harvests. The savings group helped me a lot. In 2013 I took a loan to buy

two bags of 10kg maize seed. That was the end of using seed from past harvests.) (P8)

Five participants shared how they used their annual share-out to buy diverse agriculture inputs. At this point, each member receives a lump sum that they use to achieve individual objectives. This affirms the relevance of the collaborative advantage theory's proposition, on how collectives can function as platforms for realising individual objectives.

Since 2013, whenever I receive my share-out from the group, I make it a point to use part of the money to immediately buy agricultural inputs for three of the crops that I grow. We usually share-out in December and I immediately buy my 15kgs of maize, 5 kgs of groundnuts and 5 kgs of sorghum seed for the next planting season. If I was not part of ISAL, I am certain this would not have been possible. I never did this even before sickness. (P9)

According to Masuku et al., (2015:10) engaging in multiple or diversified economic activities is a coping strategy adopted when households experience food and income security. The findings from this study show how diversification is adopted as a resilience building strategy. It was not determined from this study whether the adoption of diversification by participants was a lesson they had learnt during their experience with the negative effects of sickness.

Transition from informal to formal sector income earning activities

One participant revealed her experience of how ISAL contributed to the transition from informal to formal sector IGA. Being able to formalise a business is a sign of significant transformation and empowerment of the owner.

Muna December 2014 ndakashandisa chikamu che$500 yandakawana kubva mukugovana ndikanorhenda chitoro chaisava nerizinesi chavatete vangu paMaregere business centre. Muna 2015 ndakawana mukana wekuvhura chimwe chitoro panerimwevo business centre reRusununguko. Ichi chitoro chaiva nerizinesi rekutengesa girosari nedoro. Izvi zvakawedzera mari sezvo ndaitengesa zvakawanda pazuva kudarika chitoro chekutanga. (In December 2014, I used part of my $500 savings share-out to rent from my aunt, an unused licensed retail shop at Maregere Business Centre. In 2015, I got an opportunity

to open another retail shop at a different business centre, Rusununguko. The new shop had the advantage of having a license to retail general grocery items and liquor. This increased my income as I was collecting more daily sales than in the first shop.) (P1)

Though this was a single case from the study sample, it still points to the potential that ISAL has in enabling the growth of businesses for entrepreneurial members. Such achievements and the impact they have on income-earning can be used to showcase the incremental economic empowerment of individuals involved in ISAL.

d. Effects of ISAL on household income spending

The nine participants acknowledged how participation in ISAL supported their households' spending decisions and patterns, as compared to the period they started experiencing the effects of HIV and AIDS. In all their stories, they described how ISAL financial services helped them restore their ability to spend on a wide range of needs that had either been stopped or suspended because of the effects of HIV and AIDS. While there were similarities in some areas of spending, there were also variations, depending on the circumstances of households, such as having or not having school-going children, age, marital status and the number of members affected. Some participants expressed their sense of achievement by referring to how ISAL helped them to be like their fellow community members who either worked or had family members working elsewhere or were married. This constitutes normative guidance, an element of social capital which occurs when individuals compare their actions or behaviours to those of others within their networks or community (Álvarez & Romaní, 2017:58). P7 summed-up the general experience of how ISAL supported the way households spent income.

Kubva zvandatanga kuita zvekukanda nekukwereta mari ndinokwanisa kubhadhara zvandinoda zvehutano, kudya nekudzidza kwevana pasina kugozhegwa. Hapana nguva yandakaita paida kubhadharwa zvinhu izvi ndikazvikoniwa kana kuti ndichazozviita mune ramangwana. (Since participating in ISAL, I pay for my health, food and children's education needs without stress. There has been no moment when I needed to pay for these expenses and I have failed or deferred them.) (P7)

Improved ability to spend on healthcare and other priority daily needs

Participants shared the change in their self-confidence since joining ISAL, as they could pay for healthcare expenses and other priority daily needs such as food and education. All participants revealed how, since joining ISAL, their households paid for healthcare expenses using methods they regarded as easy and without the stress, they had experienced at the onset of the effects of HIV and AIDS. They explained how they paid for healthcare expenses using profits generated from IGAs financed by resources from ISAL.

> *Kubva zvandapinda munezvekukandirana nekukweretesana mari handisati ndamboita dambudziko rekuwana mari yekuti ndiende kuchipatara. Nguva dzose ndinenge ndiine mari inodiwa kubva mukutengesa murivo. (Since I joined ISAL, I have not had challenges to raise the money needed for hospital visits. I always have the required cash from my vegetable sales.) (P4)*

Some participants explained how they used loans from the groups to directly pay for healthcare expenses. The expenses required to be paid when participants did not have cash. Being a member of ISAL was described as an entitlement to such loans and they found this source more appropriate.

> *On two occasions when I did not have cash, I got loans from my group that I used to pay for healthcare expenses; visiting a private doctor and buying prescription drugs. I did not need any effort as this is an agreed entitlement for every member. (P9)*

P2, P3, P6, P7 and P8 all described occasions when they got loans for paying healthcare expenses such as hospital visits and admissions. When asked "How would you pay back the loan if this was used for healthcare expenses that do not generate profit?" participants described how their groups knew they had active IGAs that would be used for repayments.

> *The group knew I did not have cash at that point, but they were confident that I would pay-back from my IGAs that all members were aware of. (P7)*

Similarly, in Malawi, Weinhardt et al., (2017:716) studied households vulnerable to HIV and AIDS, where findings showed how loans from groups were used to pay for healthcare expenses. The ability to take consumption loans and repay them marked a change from the

fear of loans that was shown during sickness. There was a greater sense of confidence in the ability to repay, which was shown through the collective of ISAL activities. This helped participants to avoid the stigma of being perpetual borrowers, that was experienced at the peak of sickness by some participants.

Since participating in ISAL, five participants acknowledged how their households had experienced improved food availability. They were asked, "Why do you say your household had improved availability of food?" They revealed that this was partly because the production of vegetables had been restored and they had improved access to income that they used to buy food on the market.

> *Since reviving my IGA with ISAL loans, I produce enough vegetables to always sell and when needed, for the consumption needs of my household. (P3)*

The participants described how the increase in access to income from IGAs supported by ISAL loans changed how they could make food purchases. The participant expressed improved ability of their households to regularly pay for their food needs.

> *Mari yekutengesa yandinowana pazuva kana pasvondo inokwana kuti ndiise padivi yekutenga zvekudya zvemhuri chero patada. Kubva zvandapinda mune zvekukandirana hapana zuva rakavapo randakakoniwa kubikira mhuri sezvo ndichikwanisa kutenga zvandinenge ndichida kana ndisingazvirimi. (The daily or weekly sales I make are enough for me to spare cash to buy food for my family whenever I need to. Since I joined ISAL, I have not had a day when I failed to prepare a meal for my family as I can afford to pay for what I want if am not producing it.) (P8)*

Similar experience of not struggling to buy food was shared by P1, P2 and P6. They expressed that the change was not just about the ability to pay, but also accessing better quality food than before.

Seven participants revealed the importance of access to food when one is on ART. This motivated P1, P2, P3, P6, P7, P8 and P9 to always reserve a part of their IGA products for household consumption.

When I have 25 broiler chickens, I reserve 5 for my family's consumption. I do this because when on ART you must access good food. My son usually asks for food that has salt and I readily have the chickens. (P1)

The experience of P1 was a recurrent theme with the other six (6) participants. Their descriptions demonstrated how their IGAs were linked to both income-earning and household consumption.

Another notable change acknowledged by P1, P3, P6, P7, P8 and P9 was that since being involved in ISAL, they had increased frequency of meals. They were asked "What do you mean by an increase in the frequency of meals?" and all reported that this was an average of three per day.

Since participating in ISAL, my children eat much better food than before and are assured of three meals per day. (P1)

The ability of ISAL to support households to experience improved access to food, frequency, and diversity of meals is similar to what was found by Weinhardt et al., (2017:718-9) in Malawi, among households affected by HIV and AIDS.

Seven participants had withdrawn children from school at the peak of the effects of HIV and AIDS. Most of these households shared their personal experiences of how ISAL had restored their ability to spend on the education of their children. This finding on the use of loans for paying educational expenses by persons affected by HIV and AIDS was also found in Malawi by Weinhardt et al., (2017:716). As with other priority expenses, participants explained how the households could get loans directly from their groups or used profits from IGAs. They acknowledged how ISAL loans supported their households to manage situations when their cash flow was low.

In 2014 I used one loan from my group to pay school fees for my twins to get back to school where they had dropped out for two years. At that time my vegetables were not ready for sale and the group was my only choice and the easiest and most reliable source of financial support. (P1).

P2, P6, P8 and P9 had a similar experience where on several occasions, they used loans from ISAL to pay for educational expenses. Additional reasons that were given included that they did not want to sell their small livestock or disinvest part of their IGA capital.

One participant explained her desire to minimise the risk of the children's attendance to school being affected by unanticipated health expenses by using ISAL loans to pay school fees in advance. This behaviour demonstrates how the participant used their experience with the effects of HIV and AIDS to shape their present behaviour and the future of their family, on managing expenses related to education and family emergencies. This ability of the individual to use their experience to construct their present and future world from their past is an attribute in storytelling, according to Brown (2017:219) quoting Crossely and Sarbin.

> *I took 3 loans from my group in 2013 and 2014 that I used to pay for my children's school fees in advance. I paid off the loans. I did this because I wanted to be assured that whatever family emergency was to happen my children's attendance at school would not be affected. (P6)*

Another participant described the same financial management practice as P6. However, instead of using loans she paid from the annual lump-sum share-out received from ISAL.

> *When I received my share-out in 2015, I paid the annual school fees for my two children. I have already done the same for 2016. I am assured in a year I will not have any competition of decisions with healthcare expenses. (P9)*

In addition to ISAL loans, participants described how they used profits from their IGAs to pay for education expenses for their children. In expressing their restored ability to pay for education needs, there was an expressed sense of self-esteem.

> *I use profits from my IGAs to set aside money every month for my three children's education. I pay school fees on time. Since participating in ISAL I have not known what it means to have my children miss school for non-payment of fees. If they do, it will be for other reasons such as sickness. (P3)*

The participants described how their households did not only value being able to pay for school fees only. This included other expenses that ensured their children went to school with some basic provisions.

> *Gone are the days my children go to school without the right uniform and basic stationery. I always buy these at the beginning of each school year. (P2).*

This experience was shared by P1, P3, P7 and P9. There was an indication of the influence played by community views, on the characteristics of children who go to school from a caring family and parent. Children who went to school without a complete uniform were believed to be coming from a family that did not value their children's education. This demonstrates how the narratives of individuals can be shaped by the community values within their context. This affirms the argument by Moezzia et al., (2017:3), on the importance of social context in stories. There is a likelihood that if the same story was told in a context where uniforms and education were viewed differently, a different storyline could have emerged.

Restored ability to spend on improved agricultural inputs

P1, P2, P4, P7, P8 and P9 shared a similar experience of using share-outs from ISAL to buy improved maize seed varieties. This was associated with restoring increased crop productivity and incomes.

> *Since joining ISAL in 2011, I have been using my share-out to buy improved maize seed. I started with one 20-kilogram bag and then two per season. I have restored my crop productivity to levels that exceed those before I experienced the effects of HIV and AIDS. I have not less than 15 bags to sell to the market. (P7)*

In addition to individual initiatives, P4, P5 and P6 of the Progress support group described how the group bought improved inputs in bulk. These inputs were then shared among members. This was a typical case of the collective being used to achieve individual objectives as explained by the collaborative advantage theory.

My group annually buys improved maize inputs in bulk which are shared by members. In 2014 and 2015 as part of the share-out, I received 50 kilograms of improved maize seed. Using the right inputs improved my productivity. (P6)

P5 corroborated having received inputs from the Progress support group. The participant had no experience spending on inputs as he farmed on the same land with his parents. He explained how he used his share of inputs to plant his piece of land that was allocated by his parents.

In October 2014, I received a 10-kilogram bag of improved maize seed as part of the share-out from the group. In previous seasons, I did not plant anything on my own. The inputs I received prompted my parents to allocate me a piece of land where I planted my crop. (P5)

P2, P3, P6 and P8 described similar experiences of using part of their loans to pay for agricultural labour during the weeding and harvesting of their crops. When asked "Why was it important for you to hire the labour?" they indicated this was to make-up for family labour they had lost due to either death or sickness and disruptions to the production activities.

I used part of the loans that I got in 2013 and 2014 to pay for labour to assist with crop planting and weeding. Being able to pay for labour helped me to fill the gap my household had since my husband passed on. (P3)

The experience shared by participants demonstrate the role that ISAL played in restoring the ability for persons affected by HIV and AIDS to access improved quality inputs and mitigating the effects of labour shortage. As already pointed by Masuku et al., (2015:9) illness and death inhibits on access to quality inputs and labour by households.

Assured access to daily grocery provisions

There were six (6) participants who described how their ISAL groups created an opportunity for them to save for bulk purchase and distribution of daily groceries. The groceries were kept by one member and shared equally to all members at an agreed time. The grocery items included sugar, bath and laundry soap, baking flour, cooking oil and cooking utensils, rice and lighting matches.

Muboka redu reStar imwe neimwe nhengo inokanda madhora mashanu pamwedzi anoshandiswa kunotenga girosari rinosanganisa shuga, sipo yekugezesa, flower, mafuta nezvimwe zvekubikisa. Zvatinenge tatenga zvinogovanwa kaviri pagore musi wa12 July na12 December. (In Star Support Group each member saves $5 per month to buy bulk groceries of sugar, bath soap, baking flour, cooking oil and cooking utensils. The grocery is shared twice a year on 12th June and 12th December.) (P1)

The description by five other interviewees, from Star, Progress and Persistence support groups corroborated the experience of receiving bulk groceries. P1, P2 and P8 described, how they benefitted twice a year from the scheme as they participate in more than one group.

I practice ISAL in two groups, Star support group, and Pride group. In Pride, we buy sugar, rice, soap, cooking oil and salt like those in the support group. So, I receive double groceries and in a year, I do not have to find the money for these commodities. (P1)

The participants stated that this arrangement had benefits of lower prices they got after being discounted for buying in bulk and when sharing transport costs. Through this arrangement, households were assured access to bulk groceries they used over several months in a year. They revealed how this removed the burden for them to have and use cash every day and made it easier for them to spend on other daily needs.

I do not have to buy these grocery items for 10 months. I have much less pressure on my income because of the bulk groceries. I can plan for my medical expenses knowing that I already have other needs covered. (P3)

The groceries were described as having helped households to better plan on the use of income. P1, P2, P3 and ST 8 described how income earned from IGAs would be directed to cover other needs of the households not included in the groceries.

With the groceries, I have a good place to start when planning to provide for other daily needs. I use the income from other enterprises to buy perishable food such as meat and bread. (P8)

Beyond the changes in financial spending, P1 and P8 described how their self-esteem was restored by their access to groceries. The reference to similarity to other community members was made. This is an indication of how prevailing community values can influence the narratives of individuals.

In the last three years, I received groceries from my group. My share gives me a great sense of fulfilment and I feel no different from other households in my village that have members who work. (P1)

The experience of participants during sickness and before ISAL shows they were struggling to meet daily needs including food. Studies by Mbereko et al., (2019), Dasgupta et al., (2016) and Pienaar et al., (2017) report on coping strategies adopted by households to cope with effects of sickness. The strategies include borrowing, begging and selling assets to meet their food needs. In this study the experience of participants after participating in ISAL demonstrate a restored ability to spend on food and to even store reserves for the future.

Increased spending on household productive and non-productive assets

There were participants who described their use of ISAL financial services to acquire productive assets. They were probed on "Why are the assets important to you?" They revealed how the assets could be used to generate income or they could reproduce and if need be, sold for income. They narrated how they used the assets such as cattle for draught power in crop production.

In December 2015, I used my $500 share-out to buy two cattle and 2 goats. They since reproduced, and I now have 4 cattle and 6 goats. I use cattle in crop production and transportation. I start land preparations early ahead of the rainy season which is a good practice to get a good harvest. I save money by not paying someone to till the land. (P1)

Some participants described how the small livestock they bought could be sold for cash that they can use for emergency expenses. In doing so, participants had set-up their mechanism for mitigating the effects of economic shocks. This ability to find solutions to anticipated risks is a positive proxy for the empowerment of individuals.

> *In the 2014 share-out, I bought one goat, which reproduced, and I now have 3. If I have an emergency expense, I can sell them for cash. (P4)*

P3, P5, P6, P7, P8 and P9 shared the same experience of acquiring small livestock for a similar purpose. Despite this, most had not yet sold their livestock to meet emergency expenses as they could access money from ISAL.

> *I have not sold any small livestock yet, as loans from the group and cash from share-outs have come in when I needed money. (P7)*

One participant who sold their small livestock described how this helped them to settle education expenses. This is unlike in the period during sickness when such assets were being sold to pay for healthcare expenses.

> *In the past three years, I bought 4 goats that reproduced. I was supposed to be having 10 but I have 8. I sold the other two that were a bit old and I used the money to pay for my children's school fees. (P8)*

The case of P8 shows how this was more a choice to replace an old asset than one forced by conditions such as sickness. One participant described how the assets changed their attitude towards reliance on loans from friends and relatives.

> *In the past, I took loans from friends and relatives for family emergencies. Now, these goats are the solution as I can sell them anytime when there is a need. The habit of borrowing was giving me a bad reputation in the community. (P6)*

A participant acknowledged how her ability to acquire livestock through ISAL will help her household in upholding local marriage custom and intergenerational wealth accumulation. This is a further demonstration of the effects of community norms in shaping the narratives of

individuals. Understanding the behaviour of P1 required a reflection of the community they lived in.

> *I have male and single children, who will marry at some point and in our custom livestock are used as part of the formalities. Also, parents are expected to have assets that their children can inherit. The cattle and goats will allow me to fulfil tradition. (P1)*

There were two participants who shared how ISAL supported them to spend on assets, wheelbarrow and plastic containers, which increased the availability of their labour for other activities, reduced the labour time and made it easier to fetch water.

> *In 2014, I used part of my $300 share-out to buy two wheelbarrows and two 200 litre plastic containers. I used to make three trips per day to fetch water using a 25-liter bucket that I carried on my head from our water source that is about two kilometres away. Since I bought a wheelbarrow, I fetch water once for the whole day. This saves me time for other activities. (P3)*

P8 described how she also bought a wheelbarrow that the household uses as P3. P8 described her use of the wheelbarrow in productive activities.

> *I use the wheelbarrow to fetch manure to apply on my vegetables and this helps to improve both the quality and quantity of the vegetables that I produce and sell. (P8)*

P8 explained how she also used her wheelbarrow to carry maize for milling. She indicated that this allowed her to take more maize for milling at a time than she would carry on her head.

> *When I take maize for milling, I use my wheelbarrow to carry one 50-kilogram bag of maize instead of taking only 20 kilograms on my head. I go to the mill less often and use the time I save to go out selling the different products that give me income. (P8)*

The P3 described how her household bought two 200 litre containers they use for water harvesting which saves the time they spend fetching water. She explained that they could use the extra time to engage in other household activities that increased their income.

> *The 200-liter containers are very helpful for harvesting and storing water. I use the water for washing and cooking and I do not always have to go to the water point. I use the extra time for my IGAs. (P3)*

P2, P3, P6, P7, P8 and P9 described how through ISAL, they invested in non-productive assets such as household furniture and shelter. In their explanations, they acknowledged how this improved the quality of life for their families.

> *In 2015, I was sleeping on an old mattress while my children slept on the floor. I used part of my share-out to buy a new bed-set; a base and mattress. I gave my children to use my old bed. In winter, my children do not have to experience the discomfort of sleeping on a cold floor. (P6)*

P9 shared a similar experience that improved the well-being of her family members when she got blankets through her group. The influence of choices made by groups on the opinion and status of individuals was seen in such actions.

> *In April 2015, my group agreed that each member must ensure the warmth of their children ahead of the winter season. We bought a blanket for each member. I am proud that the group helped me to do that for my children. (P9)*

P8 described how she acquired a new asset and its significance as a status symbol. The status was defined by the community and not the individual.

> *In 2013, I bought a metal kitchen dresser which has a status element. Even if my utensils may not be of the best quality people will never get to see that as they will be stored in the dresser. An organized woman cannot be seen having her kitchen utensils in a cardboard box. (P8)*

Through ISAL, P7 described how she bought an asset that enabled her to be a role model for others. As a coordinator of community development projects, she wanted her actions to influence those that she supported. This interface between the individual action and expectations of the community demonstrates the inter-dependence between actors and the system.

> *In 2014, I got a loan of $295 and bought a new living room set of seats. I participate in and coordinate several community development projects. For me to be a role model for those who visit my house, I must also have assets that motivate them. (P7)*

Three participants of the Progress support group explained how ISAL helped them to improve the quality of their homesteads. Their group bought house roofing sheets in bulk from which each member received 5.

> *In 2013, my group agreed to help members improve their homesteads. At the end of 2014, each member received 5 roofing-sheets, but my household got 10 as I am in the same group with my wife. We used the sheets to put a new roof on our family house. I feel equal to other households in my village that are not affected by sickness. (P4)*

P5 described how he used the roofing sheets to build his new home. This was only possible because of their membership in a group.

> *I lived in the same house as my parents. In 2014 I received 5 roofing sheets and constructed a two-roomed house. I am proud of the space and feel no different from my friends working in town. (P5)*

P1 shared how she repainted the family homestead using her share-out from ISAL. She was asked to explain "Why was repainting important to your family?" She explained that the improved outlook of the homestead earned her respect from the community and developed her self-confidence.

> *I used part of my 2015 share-out to buy paint and hiring a painter to repaint the family homestead which now looks alive. Fellow community members respect me as some thought that after the loss of my husband the homestead would collapse. (P1)*

P5 explained how he used the ISAL share-out to buy a solar lighting kit. He appreciated the well-being this brought and his ability to better manage household spending.

> *I used my 2014 share-out to buy a solar lighting kit. My family has safe and healthy lighting. I also save money unlike other options, such as candles, that require regular replenishment and one to always have cash on hand. (P5)*

Disposing of assets is a coping strategy that households affected by sickness adopt, according to Mbereko et al., (2019), Dasgupta et al., (2016) and Pienaar et al., (2017). This is confirmed by this study, as participants sold their chicken and goats to pay for healthcare expenses. In this study participants shared how through ISAL they were able to restore and accumulate assets that addressed their productive, welfare and wellbeing needs. In a study in Ghana the findings confirm the contribution of the ISAL methodology in improving ownership of assets (Kwarteng and Sarfo-Mensah 2019:142).

Increased ability to save

P1, P2, P6, P7 and P8 acknowledged that ISAL had helped them to build their confidence and motivation to save. During sickness few of the participants had expressed that they had savings.

> *In late 2013, I and few members wanted to save more than $2. We formed a new ISAL group, Pride, where we saved $10 per month. I still wanted to save more, and the Pride group agreed to have my son recorded as a member though he would not borrow. I saved $20, instead of just $10 and at the end of cycles I received two share-outs. I am motivated to work hard on my IGAs as the more profit I get means the more I can save. (P1)*

P2 also described how she was in a group where they, like P1, agreed to increase their savings to $10 per meeting. Other members described how they increased individual savings behaviours outside the groups.

> *The experience with sickness taught me the importance of planning for healthcare expenses. I know what it costs for my travel to and from the hospital and the services and treatment. I always keep enough money for two healthcare trips just in case there is an emergency. (P8)*

P6 explained how she saves for both health and education expenses. This was in response to the painful experience they had gone through at the peak of sickness.

> *I save $10 every month which I use for education and health expenses. In the past two years, I always paid school fees on time. (P5)*

A study by Mbereko et al., (2019) in Zimbabwe found households drawing their savings to meet healthcare expenses, similar to what some of the participants shared. Participation in ISAL by participants restored and even motivated them to explore different ways to increase their savings. The influence of being in a group is closely related to how the savings behaviour of individuals was developed. There are participants that would not have saved had it not been that they were motivated by the group. Others belonged to more than one ISAL activity as they had experienced the positive benefits from their initial groups. The findings on how ISAL supported affected households to save is similar to what was found from households affected by HIV and AIDS practicing ISAL in South Africa (Barber, 2011:22).

Changing pattern of household debts

P5, P6, P7, P8 and P9 revealed how they no longer repaid loans from friends and relatives. They described how this was supported by ISAL which they regarded as a more reliable and preferred source of loans than other local options.

> *Since I joined ISAL, I have not borrowed money from friends or relatives. Though these helped me in the past, I did not always get the money that I wanted. The only loans I get are from the two groups where I practice ISAL. (P5)*

P5, P7 and P9 described how since participating in ISAL they paid-off debts. They accumulated the debts during the peak of the effects of HIV and AIDS.

> *The multiple income sources helped me pay off my debts with friends and relatives and the schools. Since 2014, I do not owe anyone money. (P9)*

During periods that participants had a sickness, their household budgets included payment of debts as a regular household expenditure. They expressed a sense of relief in overcoming this, since they participated in ISAL.

> *Kana une chikwereti chemari yemunhu, chero sahwira, zvinhu zvinorema. Munguva yekurwarirwa ndowaiva muraramiro mwedzi woga-woga. Uchifamba vanhu vanokureva. Kubva zvandapinda mumukando ndakakwanisa kupedza zvikwereti zvangu. Pane vamwe ndinosvika nekutaura ndakasunguka ndichiziva kuti handina angandifumura achiti ndine chikwereti chake. (When you owe someone money, even a close friend, it is a very heavy burden. During the time we had sickness we lived on this heavy burden every month. When you walk people talk about you. I now interact and talk with others with freedom knowing that no one will mention that I owe them money. (P8)*

The findings show how ISAL had varied effects on the reliance on debt by households. In the period during sickness, households used loans to meet urgent healthcare expenses. Accessing the loans from friends and relatives was seen as a last resort, at times not reliable and lowering self-esteem. After participating in ISAL groups were seen as the preferred, assured and entitled source of loans. The participants used loans for both productive, investment and urgent needs. Even where loans where taken for urgent needs, the participants and their groups knew they had the means to repay from their IGAs. The ISAL loans were only helping the members to manage cash-flow situations.

4.4. CONCLUSION

The chapter presented findings from the life stories of nine participants that were affected by HIV and AIDS and participated in ISAL activities. The findings elaborated on how HIV and AIDS negatively changed income generation and spending. The HIV and AIDS effects that

initiated changes were sickness and provision of care and support. These had compounding effects that included reduced attention and abandonment of productive activities which reduced productivity and incomes, forced disposal of assets, increased household debts, reliance on begging and foregoing expenses for food and education. The findings show how ISAL positively supported both income generation and spending as loans and share-outs were used to restart, start-up new and expand IGAs, restore the use of improved agricultural inputs, acquire productive and non-productive assets and improve homesteads. Households improved and increased their incomes and ability to spend on healthcare and other daily needs and savings to levels similar to and better than before the effects of HIV and AIDS. Chapter 5 presents a discussion on the findings of the study and draw conclusions, as well as recommendations.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1. INTRODUCTION

This chapter presents the conclusions drawn from the study findings and how these can be understood in the context of existing literature and using theoretical frameworks. Following this, the chapter presents areas recommended for inclusion in HIV policy and programme responses. This is followed by a presentation of the areas of further research that emerged from the findings. The remaining part of the chapter presents the conclusion.

5.2. SUMMARY OF THE STUDY

The purpose of this study was to explore how participation in ISAL changed the way that persons affected by HIV and AIDS generated and spend their income. To understand the support better, the participants initially shared the changes that HIV and AIDS had caused on how their households generated and spent income. Thereafter, they shared the experience of how this changed when they participated in ISAL financial services. The study, therefore, had to answer two key questions and each had two generative questions that were administered to the story tells:

1) In what way does HIV and AIDS change the way persons affected by HIV and AIDS generate and spend income? The related two generative questions were:
    a. How does HIV and AIDS change the way households generate income?
    b. What way does HIV and AIDS change the way households spend income?
2) How does participation in ISAL by persons affected by HIV and AIDS change their generation and spending of income? The two generative questions were:
    a. How does access to ISAL financial services change the way households generate income?
    b. How does access to ISAL financial services change the way households spend income?

A thematic approach was used to analyse the individual findings and cross-analysis between stories. The main themes generated included changes caused by HIV and AIDS to the structure of productive activities, the levels and frequency of income earning, what the household spend their money on. These themes are similar to those generated by HIV and AIDS-related studies (Jennings et al., 2015; Tsai et al., 2014 & Saha, Kermode & Annear 2015)

5.3. SUMMARY OF FINDINGS

a. Changes caused by HIV and AIDS on income generation

The findings point to the high vulnerability to the effects of HIV and AIDS of livelihoods that are dependent on labour-based productive activities. The experiences of the interviewed members clearly and consistently demonstrated that the effects associated with HIV and AIDS caused the reduction and loss of income earning sources and levels. The changes were triggered by two distinct yet related effects of HIV and AIDS on labour; the sick household members and the members who provided care and support. The effects of HIV and AIDS on productive activities observed in this study are similar to what has been found in other contexts (Otieno et al., 2017:46).

The findings reveal that the duration of the effects of HIV and AIDS influences the intensity of experience that the household has with changes in production, sources and levels of income. Members who experienced the effects of HIV and AIDS for four to seven years tended to express the more intense experience of the negative changes to how they generated income. Long periods of sickness intermingled with frequent healthcare-seeking travel significantly disrupted operations of productive activities and are associated with the inability to perform some agricultural tasks, neglect of in-field crops, loss of perishable stock and inability to trade. Households whose members had shorter periods of sickness experienced lesser changes to production and income-earning. The areas of change in the economic characteristics of households observed in this study are largely similar to those observed by Wafula et al. (2013) among rural households affected by HIV in Suba District of Kenya.

The economic empowerment theory highlights that empowered households must demonstrate the ability for self-sufficiency (Tangaa & Tangwe, 2014:188). This can be interpreted to include being able to independently work and generate income and provide for the needs of their families. In the period after sickness, the findings demonstrate the disempowering effect of sickness that participants experienced. The experience of participants included their inability to meet the food needs of their families, not seeking healthcare service and children dropping out of school because of a lack of income. The stories of begging and being indebted to friends and relatives marking the insufficiency of their means. A marked contrast of narratives is experienced after the same members participated in ISAL activities. The experience of participants paints ISAL as providing them with access to financial assets. The assets allowed

them to apply their capability to restore productive activities that had either closed-out or were operating below capacity during sickness. When the assets of households are expanded, and their capabilities are applied empowerment is attained (Tangaa & Tangwe,2014:188), quoting the World Bank.

The findings from the study show how sickness compromised one of the pillars of economic empowerment theory; the individual agency for change. Agency, as argued by Zimmermana*,* Lia, Moreaua, Wilopo and Bluma (2019:1), entails the individuals having the capacity to make purposeful choices. The increasing severity of sickness, loss of productive labour and reduction in type and number of productive activities left participants with a lack of capacity for purposeful choice to meet their daily needs. Instead, what the participants shared was how their choices were made more by circumstances than choice. This included changing types of food consumed because the households could neither produce nor purchase because they lacked the labour and means. Participating in piece jobs became a means of survival for some, despite the associated stigma of failure. Some participants sold assets such as chicken to meet healthcare expenses instead of the intended choice of agricultural inputs. The purposeful choice is restored through the opportunity to access loans and cash lump sums from ISAL activities. Participants shared their experience for purposefully saving and taking loans to meet healthcare and education needs and buying improved agricultural inputs.

A combination of empowerment and collaborative advantage theory applies to the conduct of groups in which the participants were members. In the period during sickness, the participants belonged to AIDS support groups that did not have an economic orientation. Participants experienced challenges to meet their income generation and spending needs. A change is experienced, from the point when ISAL was introduced to the AIDS support groups. Through ISAL, participants shared how groups used savings to buy agriculture inputs, groceries and building materials for members. First, the groups made the purposeful choice, indicating the possibility of attaining empowerment through community structures. Second, they used the group structure as a pathway to meet individual objectives and some group objectives were used to meet individual needs. In collaborative advantage theory, there is an interplay of motivation and influence between individuals and groups in the formulation and achievement of goals (Vangen & Huxham, 2013:5).

Several participants relied on external financial support from friends and relatives to meet their daily needs. This, to some extent, showcased the important role of social capital as a channel through which those involved can realise benefits (Campbell, 2013:116, quoting Bourdieu). In his conceptualisation of social capital, Campbell (2013:116) refers to the advantages arising from membership of community groups. The interpretation from this is that social capital is associated with positives. When participants had a sickness, relatives helped to pay the bills, while some provided accommodation and others food. The findings from this study, at some point also counter this conceptualisation of social capital as having benefits. Where the reliance on friends and relatives for economic support was perpetual, the findings show that there are limits and negative consequences. Clearly from the findings, transactional relations that appear to be beneficial to individuals at face value in fact hide unpleasant experience. Being financially assisted by friends and relatives was at some point not an issue of choice for the participants, but the pressure from the effects of sickness. Participants shared the stigma and shame they experienced as they sought assistance from friends and relatives.

Reduction in household members involved in productive activities

Ahlborg, Svedberg, Nyholm, Morgan & Nygren (2019:3), quote Coleman, in referring to a sub-concept of social capital which they call family social capital, that spans from parent-child to siblings and other family members. The strength of this family level social capital is observed in the findings from this study, on the response to sickness. Participants narrated how they sacrificed their time from productive activities to provide care to the sick. This included travelling to different places and being consistently present at home to be on hand to provide any needed attention to the sick. Indeed, the sacrifices also showed the negative outcomes that can arise from this type of family-level social capital. As other family members were sick, HIV and AIDS reduced the number of household members who participated in productive activities. Households applied less manpower than required by their productive activities. The effects of HIV and AIDS on the availability of productive labour and disruptions to productive activities found in this study are also observed in Zimbabwe by Muzari, Mpofu, Musiyandaka and Gatsi (2014:64).

Caregiving to the sick demonstrates the importance of intrapersonal and interpersonal relations in household-level response to the effects of HIV and AIDS. The nuclear family relations and the desire to restore the health well-being forced caregivers to provide their labour and time to care for the sick, whether at home or travelling to seek healthcare services.

Caregivers dedicated less time to productive activities and as sickness deteriorated, households experienced more frequent and extended downtime on their productive activities. This diversion of labour leads to a reduction of income earned by households (Poudel et al., 2015:503).

Loss of regular wage income

Three participants who had employed family members experienced the direct effects of HIV and AIDS on productive activities at three levels. The first two are what all households experienced with the loss of productive labour and caregiving responsibilities. Before the effects of HIV and AIDS, household members who were employed used their leave, weekends and public holidays to travel to rural homes to provide their labour in crop and livestock production. When they fell sick, they either returned home to receive care or caregivers travelled to areas of work to provide care, thereby reducing participation in productive and income-earning activities. Households experienced a reduction in the flow of remittances by employed and sick family members (Poudel et al.,2015: 503). When sick members died, the three households experienced a total loss of regular wages.

Types of healthcare services and their effects on productive activities

Households that did not use healthcare facilities to get treatment had more intense negative effects on their productive activities. The use of local ineffective remedies bought from retail shops had members being sick and not involved in productive activities for long periods. Households that used healthcare facilities tended to have less intense effects on their productive activities. The cause of the sickness was diagnosed and got the right treatment that helped them to restore the health and productivity of sick members, though not always at the same level of intensity as before sickness. The efficacy of the source of healthcare therefore, influenced how households affected by sickness could have their ability to be empowered restored. The rationale that participants gave for prioritising spending on health when they had income was to have the sick family members healthy and involved in productive activities. When participants participated in ISAL, the health of family members remained a priority. They set aside savings, took loans and bought assets to ensure their ability and preparedness to pay for health emergencies. In doing so, they had their household members healthy and productive and reduced their vulnerability to food insecurity and other adversities. When households can reduce their vulnerability to adversities, this is an indicator of economic empowerment (Weber & Ahmad,2014:76).

Changes to the structure of productive activities

The episodes of worsening sickness, the location of the sick member and healthcare-seeking travel and providing care to the sick are associated with negative disruptions to productive activities. The disruptions included the late undertaking of tasks in productive activities with negative effects on the quality and quantity of production. The agricultural production-related tasks that were delayed and not properly conducted included land preparation, pest and weed management, watering, harvesting and marketing.

Households reduced the diversity of vegetables and crops they grew. They prioritised those with low demands for labour at all stages including planting, weeding, harvesting and storage. The fewer crops and vegetables the households grew the less demand was made of labour. For major crops, households no longer prioritised the economic returns, but the utility value resulting in maize being the most grown after the effects of HIV and AIDS as it is the staple food. Households either produced less or entirely stopped producing sorghum, millet, round and groundnuts as these were regarded as labour intensive. In all cases, households experienced a decrease in productivity of maize which concurs with findings from a study in Kenya (Wafula et al., 2013:155).

Rural households, including those in Bikita District, are ordinarily involved in more than one productive activity. This includes producing crops, poultry, goats, cattle, vegetables and other non-agriculture-based activities (Muzawazi et al., 207:108; Zvinavashe et al., 2015:2; Mawere and Awuah-Nyamekye, 2015; Mapuranga et al., 2015:3; Mapuva and Madyauta, 2016; Chikobvu et al., 2010:15-17). Households were forced by the effects of HIV and AIDS to reduce their participation in multiple productive activities. Most households were producing only one crop and one type of animal to match the fewer active yet overburdened labour. Consistent with the change observed in the diversity of crops, the single crop produced by all households was maize. In three households, HIV incapacitated members, thus forcing operations of some IGAs to close.

Households planted crops on pieces of land smaller in size than before the effects of HIV and AIDS. The reasons for the adjustment included labour constraints, the inability to afford inputs and reduced number of crops. HIV and AIDS is attributed to reduced land allocation for crop production (Wafula et al., 2013:154-155) and (Masuku et al., 2015:4)**.**

Before the effects of HIV and AIDS, all nine participants had productive activities, whose markets were vibrant at designated business centres and they reached out to customers within their and neighbouring villages. The business was occasionally conducted at homesteads. The effects of HIV and AIDS changed the location of operations of IGAs, the size of the market catchment area and the frequency of business transactions. They could not operate from business centres and neither could they walk to do business in local villages. This was most experienced at the peak of sickness when caregivers were confined at homes providing care or travelling to seek healthcare services. Caregivers reduced their participation in those IGAs that required them to be away from homes and this scaled down the size of the catchment areas to sell their goods and services. Some concentrated on productive activities that could be operated from home for them to concurrently provide care to the sick. Caregivers who travelled long distances from home reported higher negative changes to the operations of their IGAs. The long distances meant they were away from home for extended periods without attending to their productive activities. Crops and vegetables were not weeded and watered, leading to significant losses of harvests. Households that produced and sold vegetables shared their experiences of how they were not able to sell vegetables from home than they used to from local business centres and villages before the effects of HIV and AIDS. While the sample from this study had most households continuing with some level or reduced production amid sickness, Woreda, Nagaraja and Hailu (2016: 905) quoting Kutlwano, refer to a study in Botswana, in which affected households decided not to farm because of illness.

The effects of HIV and AIDS are attributed to eight households deciding not to use improved agricultural inputs, such as hybrid seed, pesticides and fertilizers. This was meant to save available cash for priority healthcare needs. Households planted seed reserved from previous seasons' harvest for maize, groundnuts and round-nuts. The adjustments on the use of inputs because of sickness were observed for persons affected by HIV and AIDS in Lesotho (Masuku et al., 2015:9). The change in types of inputs used by households is attributed to low crop harvests.

Households associated the use of paid labour on the effects of HIV and AIDS. This was a strategy by households to mitigate the reduced availability of labour. Two households used paid labour during crop production increasing their production costs, but their productivity remained lower, as compared to the period before the effects of HIV and AIDS. In both

households, the use of paid labour was ad hoc, which was associated with the lack of positive effect on productivity.

Changes to household income-earning pattern

There were no inconsistencies, but rather variations in the way disruptions to household productive activities negatively changed household income-earning and food availability. For all households, the compounding effects of HIV and AIDS were reduced crop harvests that in turn lowered food availability and surplus that could be sold for income. Non-farm productive activities operated less frequently, leading to low and erratic income. These factors also affect food availability, stability, access and use of food (Masuku et al., 2015:4).

The effects of HIV and AIDS are attributed to the decline and total loss of income. The nine households variously referred to reduced quantities of goods that they bought and sold, fewer volumes of goods they used to produce or sell, reduced frequency of restocking, fewer markets they reached and lower value of sales, as compared to the period before the effects of HIV and AIDS. They referred to the fewer number of bags of maize that they harvested after the effects of HIV and AIDS. They also experienced erratic access to income as the IGAs operated less frequently. Eight participants with productive activities that used to trade daily, such as vegetable production, buying and selling, retailing of clothes and groceries appeared to express an intense loss of income as they no longer operated as frequently. The difference between individuals was the margins of income loss, with some experiencing total loss, while others had losses of up to half. Households that had long periods of sickness experienced the most losses of income. Excluding wage income, there was no difference in the experience of change of income from other productive activities between households that did not have employed family members and those that had.

The poor performance of regular productive activities forced households to resort to generating income from uncharacteristic sources. Of the nine participants, seven regularly regarded and depended on the sale of assets to earn income. Assets sold were mostly small livestock such as native chickens and goats. Chickens and goats feature as the most sold livestock after the effects of HIV and AIDS (Masuku et al., 2015:7). According to the members in the absence of the effects of HIV and AIDS they would not have sold the assets which they mostly reserved for education, agricultural inputs and clothes. The effects of HIV and AIDS are noted for the pressure they impose on households to dispose of assets (Muzari et al., 2014:67).

Participants associated the effects of HIV and AIDS on productive activities with their reliance on external support networks as sources of income. Severe and long periods of sickness forced households to expect regular income support from relatives and friends and benefits from employment. The findings showed the role and strength of social capital in benefiting participants that were in HIV and AIDS-induced crisis. The financial transactions received by participants from their friends and relatives can only be understood in the social relations between the parties (Postelnicu et al., 2015). Relatives and friends regularly provided financial support to five households after the effects of HIV and AIDS to the extent that they regarded this as one of their sources of income. This support tended to be received in cases where the effects of HIV and AIDS became severe and life-threatening, and this was more apparent in cases where the diagnosis of the cause of the sickness was not known early enough. Households frequently, even monthly, received grants or loans from friends and relatives who they regarded as a source of income. Reliance on loans is a practice noted for persons affected by HIV and AIDS in other literature (Poudel et al., 2015:504)

Three participants related a shift from agriculture production to employment as the major source of income. As income from crop and vegetable production declined, wages from employment became the major contributor to household income. Households referred to occasions when medical insurance, funeral support and pension supported them with major household expenses. The loss of labour associated with AIDS-morbidity was also a finding from a study in South Africa (Woreda et al.,2016:904).

The severity of the effects of HIV and AIDS was related to begging being regarded as an acceptable source of income. Two households regularly practiced begging to raise income and they believed this was the only option they could pursue at the time. Despite this, they both were not content with the source and expressed how this negatively affected their self-esteem.

Two households regularly exchanged their labour for cash in a practice locally called "*maricho*" or piecework. This was regarded as a major contributor to household income, particularly at the peak of sickness when they could not produce with their activities. In the absence of the burden of HIV and AIDS and ordinarily, the households would not consider this as a source of income.

b. Effects of HIV and AIDS on household spending

HIV and AIDS forced households to transition from generating income sufficient to meet all their needs to income that barely covered only healthcare-related expenses. The findings show that the timing of awareness of whether HIV and AIDS was affecting the households influenced the intensity of change on expenditure and how households felt the financial burden. Delayed use of health facilities and taking medical tests is associated with more intense changes to household spending of income. In three stories, there was initially no knowledge on whether HIV and AIDS was affecting the households, they spent small amounts of money on local medicines to deal with unknown opportunistic sicknesses but without bringing the desired relief. This forced more frequent and increased healthcare expenses and demanded households to always have cash-on-hand. The households did not immediately feel the effects of small frequent expenses on overall household spending. After tests and on reflection, all households affirmed having unknowingly spent a significant part of their income on healthcare. The households also tended to have later experiences of serious or severe effects of HIV and AIDS on productive activities because they delayed seeking the right healthcare services. The severity of the effects of HIV and AIDS is a factor that can influence how households experience the financial burden of healthcare expenses (Tran et al., 2013: 215).

Households that had early knowledge of the causes of sickness appeared to express lesser burden of healthcare spending. Three participants who immediately had medical tests did not demonstrate concerns with the effects of spending on unknown sickness. After medical tests, they spent money on the right treatment. Adhering to prescribed treatment appeared to be associated with lower healthcare expenses by households and an important factor in restoring the availability of productive labour.

The two scenarios are significant as they show the advantages of early HIV testing. This aids households to access and spend on the right healthcare services while having early restoration of productive labour. While not taking tests early and spending on local remedies appears cheaper per transaction, it is incrementally expensive as there will be an extended period of frequent spending and a shortage of productive household members. These findings point to the important role of awareness as an indicator of empowerment (Tangaa & Tangweb, 2014:189). When the participants had awareness on the efficacy that comes with medical tests, they took decisions that improved the wellbeing of family members and chances of restoring their productivity.

The effects of HIV and AIDS had major changes in how households prioritised spending. After the effects of HIV and AIDS, there was convergence from all narratives that healthcare expenses became a primary priority replacing food, education, agricultural inputs and clothing. All households understood the economic effects of spending money on the well-being of family members as this restored the availability of labour in income-generating activities. Enrolling on antiretroviral therapy (ART) did not change but affirmed the long-term prioritisation of healthcare expenses on all household budgets. Findings from a study by Wafula et al., (2013:152) showed that persons affected by HIV and AIDS have high healthcare expenses.

After the increased spending on treatment services, transport fares to visit local shops and healthcare facilities became an important household expense. The spatial distance between the residence of the participants and where treatment services were received were important factors in determining the intensity of the changes that were experienced with expenses on transport. Households that used local remedies spend less per single trip on transport as they travelled short distances. The ineffectiveness of the remedies meant they travelled frequently locally and over time spend more on transport. In three of the households, where voluntary testing was not done yet, they still used health facilities, they travelled very long distances, which also meant spending more money on transport. They referred to travels to Harare and Mutare that are upwards of 335 and 220 kilometres a single trip respectively. The frequency of travel to these places could be weekly to monthly, a pattern that was shared to demonstrate the recurrence and burden of expenditure on households. The four households that voluntarily had an early diagnosis of the cause of health conditions and used the nearest reliable health facility in the district travelled longer distances than those that bought from local shops. The four households paid more per single trip as the facility is about 24 kilometres from the district centre. However, they made less frequent visits to the facility and overall, appeared to spend less on transport fares. After enrolling in treatment, the most noted change to household spending related to transport costs. Paid public transportation became a regular item in household budgets as this is required to access health facilities.

In eight stories, the effects of HIV and AIDS led to education costs being foregone, culminating in the withdrawal of children from school to avoid the expenses and save the available cash for healthcare needs. School absenteeism was observed among persons affected by HIV and AIDS in Kenya (Wafula et al., 2013:157). It is worth noting that in all cases, withdrawing

children from school was regarded as a difficult decision because of the knowledge and belief that the parents had on the future value of education to their households.

After the effects of HIV and AIDS, households reduced their spending on savings. The lower incomes and high healthcare costs were associated with households not having surplus cash to save. In Kenya, Wafula et al., (2013:154) also found rural households affected by HIV and AIDS withdrawing their savings for use in healthcare and funeral expenses, among others.

Before the effects of HIV and AIDS, five participants spent on clothing, household utensils, and cosmetics. After the effects of HIV and AIDS and associated spending on healthcare services, these were regarded as non-essential and households stopped spending on them.

The effects of HIV and AIDS are associated with changes in the sources households used to access food. In eight stories, before the effects of HIV and AIDS, the major sources of food were own crop and small livestock production and occasional purchases from the market, which were largely regarded as sufficient. After experiencing the effects of HIV and AIDS, households had irregular and low crop and vegetable harvests that were not sufficient to meet their usual consumption needs. Muzari et al., (2014: 68) made similar observations on how households affected by HIV experienced reduced food availability in Zimbabwe. The effects of HIV and AIDS led some households to increase market purchases to cover the food gap, but in all cases, substituting with cheap and low-quality food types.

HIV and AIDS was associated with the introduction of new expenses for hired labour to the budgets of households. In one household, every visit to the health facility required someone to be hired to provide child-care services. Three households hired paid labour in crop production to make-up for own labour that was compromised by the effects of HIV and AIDS. This change has been found among HIV and AIDS affected households in Kenya (Wafula et al.,2013:156) that when lacking their labour, they resorted to using hired labour.

The onset of the effects of HIV and AIDS was associated with households incurring loan repayments as part of monthly expenses. The worsening and long duration of sickness, high frequency of healthcare spending and reduced income generation were the drivers of this new expense. Pascoe et al., (2012:15) associate food insecurity as a push factor for persons adopting risky sexual behaviours. This line of thought can be used to conclude that increasing health expenses pushed affected households to rely on risky financial behaviours that they

lacked the capacity to manage. Where a household depends on external resources such as loans, the capability for self-determination maybe compromised, which may result in the loss of one outcome and indicator of empowerment (Turner & Maschi, 2015).

c. Effects of ISAL on household productive activities

Participation in ISAL appears to be associated with supporting an increase in productivity and income by all households, as compared to the period during the effects of HIV and AIDS. The increases are associated with IGAs that were restarted, new start-ups and those expanded and diversified using loans and share-outs from ISAL. The experience of positive changes to productive activities and income is also observed from research on savings and loan groups in Tanzania (Kessy et al., 2017:39). There was no experience of any negative effects of expanded social capital as participants pursued opportunities to restore, improve and increase productivity and incomes. With access to capital, participants started new IGAs and restarted old IGAs that included reaching markets beyond their areas of residence and in some cases, crossed international borders. With these behaviours, they expanded their social capital as they reached new geographies and markets where they potentially created social and economic relations, some of which could be the dangerous external world (Kondo & Shirai,2013: 265).

According to Weber and Ahmad (2014:76), feelings of self-worth and efficacy can be used to measure empowerment and from the narratives, these were lost during sickness. In the experiences shared by participants on income generation and spending, there is a clear demonstration of how the effects of HIV and AIDS had created self-stigma on helplessness and disempowerment. This is clear in practices such as disposing of assets, begging and engaging in income-generating activities that participants were not necessarily comfortable with. Since participation is ISAL, all individuals had a sense of control over the decisions regarding the income-generating activities they engaged in and the choices they made on spending income. There was a demonstration of control over actions and choices which are important attributes in the empowerment theory (Tanga & Tangwe, 2014).

The duration of participation in ISAL appears to influence how households experienced the effects of ISAL on income generation and spending. The longer the members participated in ISAL, the more profound were their experiences as they had more opportunities to receive loans they invested in their IGAs and share-outs. The loans and share-outs restored and

increased income-earning and assets to levels higher than before and during the effects of HIV and AIDS which appeared to be a strong influence on the confidence that members had with ISAL.

All households had used ISAL loans to restart IGAs which they operated before the effects of HIV and AIDS but had been closed-down or operated at below usual capacity. Restarting IGAs was regarded as easy since members had familiarity with the skills and experience and could access the input and output markets. The background was an asset in managing and reducing the risk of failure of the IGAs and assurance of access to income and restoring self-help. The experience is similar to what Wagner et al., (2012: 3) found in Uganda, where 73% of study participants engaged in the same types of income-earning activities after they regained their productive energy following sickness.

Repeat loans and share-outs from ISAL were used to start new IGAs, expand and diversify existing IGAs. The investments were meant to increase and improve household income and cash flow, acquire assets, start savings and reducing the risk of relying on one income source. Four participants revealed how the repeat loans had helped them to improve their incomes that even surpassed what they earned before the effects of HIV and AIDS.

One participant demonstrated how ISAL financial services supported the growth and transition of the operations of their IGA from the informal to the formal sector. Loans and share-outs were used to finance costs associated with obtaining the required licensing and stocking the enterprises.

A common theme from all participants was associating ISAL with increased frequency of accessing income. The restarted, expanded and diversified IGAs operated more frequently, thus increasing access to income by households. A consistent pattern for all stories was the restoration of own food production using financial services from ISAL. They used ISAL loans and share-outs to buy improved agricultural input varieties that allowed them to re-start and expand vegetable and crop production. They associated this with increased crop productivity, food availability and surplus produce to sell. Eight stories associated their investment in homestead garden production with being able to provide for daily food needs, reducing food purchases and saving and surplus being sold to generate income.

d. Effect of ISAL on household spending

A finding from all stories was their association of ISAL with restoring the ability to spend on a wide range of needs that had either been stopped, suspended or reduced during the effects of HIV and AIDS. The households could afford to pay for healthcare, food, education, small-livestock, savings, agricultural inputs and shelter needs. The improved capabilities are consistent with the indicators of the financial dimensions of economic empowerment (Weber & Ahmad, 2014:76**).** The changes were experienced through two main pathways; the use of profits from IGAs and loans from ISAL. The demographic composition of households influenced the areas where the change in spending was most experienced. These included factors such as having school-going children, age, marital status and the number of sick members.

The social capital theory highlights that community values and mutual concerns can influence the behaviours or actions of individuals (Álvarez & Romaní, 2017). Five participants mentioned how their participation in ISAL and the use of ISAL loans and share-outs were motivated by community values. Community values on destitution and the importance of self-reliance were key motivators not only to participate in ISAL, but decisions on spending as well. Paying for the food and education needs of children from own means were values that communities regarded as demonstrating capability and responsibility. These had been compromised by the effects of HIV and AIDS. The decision by ISAL groups to spend money on blankets, agricultural inputs and building materials were borne out of the mutual concern shared by the members. This included a shared desire to improve the wellbeing of families, restoring agricultural productivity and status of homesteads. The annual sharing out of savings, the bulk sharing of groceries, farm inputs and building materials are a demonstration of the practical application of the collaborative advantage theory. As argued by Huxham and Vangen (2013), these ISAL group initiatives allowed the individual participants to achieve their objectives of investing in IGAs, meeting daily consumption needs and acquiring and improving their ownership of assets.

ISAL was attributed to restoring and improving the ability to pay for current education needs by seven participants. Households settled debts with schools and others re-enrolled children who had dropped out of school. Two households used ISAL loans and pay-outs to pay for school levies in advance as a strategy to mitigate the risk of emergencies affecting the

attendance of children to school. Similar to studies elsewhere, the findings indicate that participation in ISAL improves the ability of persons affected by HIV and AIDS to pay for the educational needs of their children (Ssewamala et al., 2016:12).

ISAL was associated with the increase in household spending on food, but also the frequency of meals consumed per day. These positive effects of savings and loan activities on food availability are similar to findings on a study in Mozambique (Brunie, Fumagalli, Martin, Field & Rutherford, 2014:117). Some households included food purchases in their budgets, something that they were not used to before and during the effects of HIV and AIDS. It was common for eight participants who produced vegetables and poultry to reserve part of the products to meet household consumption needs. All participants belonged to groups that adopted annual bulk buying and sharing of grocery items. The quantities were reported to cover several months in a year, giving assurance of food availability while removing the burden for households to regularly have cash on hand. The practice of groups pooling resources together for the benefit of members is noted for its strength as a support mechanism for members (Wagner et al., 2012:6). This connection between the individual and group goals is explained in the collaborative advantage theory.

Since participating in ISAL, all households increased their spending on assets and this included cattle, goats, chickens, wheelbarrows and homestead improvements. Some of the assets, particularly small livestock, were seen as risk prevention and mitigation measures when faced with predictable and unpredictable emergencies. All the members did not believe they would have achieved these without participating in ISAL. The acquisition of assets and sense of restored confidence are catalysts for empowerment (Tangaa & Tangwe,2014:189). They help in giving confidence in the voice of the individuals. This was evident in participants who expressed how access to ISAL made them feel equal to their fellow community members who were employed. Some participants confidently expressed how they could afford any type of food and had their children attending school with requisite provisions.

In all the stories, it was clear the ISAL methodology had an inbuilt influence for households to save than they did before and during the effects of HIV and AIDS. This is based on the different ways in which the members saved, such as participating in multiple savings groups beyond HIV and AIDS support groups. Members formed other ISAL groups with different composition of membership, thus allowing them to save more, in some cases as high as $10 per month.

One member incorporated her child in the group to save more. The introduction of commodity-based savings in all groups provided members an opportunity to access and benefit from another form of savings that had a direct impact on daily expenditure and well-being. Such proactive decision-making and action behaviour outcomes are indicative of empowered individuals and groups (Tangaa & Tangwe, 2014:189).

Households shared their relief and satisfaction with ISAL as loans and share-outs helped them to manage fluctuations in household cash and unplanned expenses. Individuals approached their groups for loans repaid on terms they set and regarded as less risky, assured and dignified. ISAL loans were used to pay off debts that households had accumulated during sickness. In all cases, members had loans from their groups and not friends and relatives. When members borrowed from ISAL, part of the money is their contribution, which reduces the level of risk.

Loans from ISAL and improved incomes are associated with the ability of households to plan for and spend on hired labour for agricultural activities to the desired levels and timing. The timely hiring of labour was partly associated with the increase in crop productivity, something they could not do at the peak of the effects of HIV and AIDS.

Participation in ISAL perceptions and aspiration

The study findings on ISAL demonstrate the important role of community groups in the HIV response, not just for the social benefits, but equally for the material support (Skovdal, Magutshwa-Zitha, Campbell, Nyamukapa & Gregson, 2013:10). Despite the positive results demonstrated by the stories, participation in ISAL was not necessarily easy for most household members. The main challenge was the economic situation of members and the lack of familiarity with the methodology. The initial savings of $5 was regarded as too high and was agreed at a time when households were struggling to be productive and already burdened by healthcare expenses.

Beyond the household-level economic dynamics, there were interpersonal and community relations that had pressure on households when affected by HIV and AIDS and before joining ISAL. Prevailing HIV and AIDS-related stigma affected the engagement of two households in IGAs. Misconceptions of promiscuity prevailed when they approached potential customers to do business. Households that borrowed money from friends and relatives expressed how they

had lost confidence and self-respect because of what they perceived as the community's negative views on their ascribed status as perennial borrowers. This partly influenced their desire to restore the ability to generate income and meet their household expenses.

The push factors for members to participate in ISAL were diverse. These included desperate situations they wanted to come out of, unpleasant experiences with the inability to meet livelihood and healthcare expenses, loss of savings and productive activities and assets, lost self-esteem and influence of other community members that were demonstrating impressive livelihood changes from being part of ISAL. The aspirations of members included using ISAL savings and loans as an empowerment pathway to avoid the recurrence of situations they had experienced, recovery and risk mitigation and resilience against future emergencies.

An experience shared across all participants was that the positive changes they experienced were not solely about the ability to spend money. Rather, they also valued the ease and dignity with which they could pay for expenses since ISAL. When they experienced the effects of HIV and AIDS, the households ultimately paid for expenses but only after pleading with several friends and relatives, hours of walking to different locations and having to dispose of assets at lower than the market prices. The experience was associated with negative effects on self-esteem and forcing withdrawal from social participation. Through ISAL, households expressed how they valued the self-worth and self-agency, they were experiencing from being able to save and take loans from a fund in which they had a stake. Expressions of self-worth by the participants are stated as indicators of empowered individuals (Weber & Ahmad, 2014:76).

If sustainability is considered as the ability of a system or practice to function beyond the time it was set-up and without external support, then the findings demonstrate the sustainability of the ISAL methodology. The groups had been practicing ISAL on their own for 3 and 8 years since they were formed and supported by BHASO. When sustainability is regarded as the ability of a system to enable households to meet their financial needs, then the findings show that ISAL has supported households to sustainably meet expenses for their livelihoods needs. Households were able to pay for daily expenses that they could not afford after and even before they experienced the effects of HIV and AIDS. The financial benefits that members' livelihoods derived from ISAL appears to be the motivation for the groups to continue functioning.

e. Theoretical frameworks and the study findings

The theoretical frameworks applied are relevant to the study. They can be applied to understand the response of both the participants and ISAL groups. They assist in better appreciating the role and nature of relations and resources transacted between individuals and their families, individuals, and groups and individuals and the wider community.

The economic empowerment theory was drawn upon to understand the disempowerment effects of sickness on the households. Assets are an important enabling factor to empowerment, yet participants lost financial, labour and physical assets of value as a result of sickness. When the negative effects of sickness and lack of assets on empowerment are shared, the vividness of their positive effects can be clear. The positive effects of assets on empowerment are seen after ISAL enabled households to access financial services, savings, loans and lumpsum pay-outs. The financial services were assets that participants used to restore and expand production, rebuild other lost assets, accumulate assets to mitigate future risks and directly pay for more diversified daily needs of households. These capabilities also positively transformed the self-esteem of the participants.

At the onset of sickness, the experience of participants showed how multi-level social capital had an important role. The family and friendship relations were used by participants to access financial and other material support to mitigate the effects of sickness. The financial support was both voluntary and solicited. In voluntary support, the friends or family of participants provided support without being requested. They observed how a lack of financial means was prolonging sickness and volunteered to assist. In the solicited support, the participants approached friends and relatives to seek financial support. Participants did get this support and in some cases on several occasions. This type of support did reveal the often unaccounted for negative outcomes of social capital. Participants who repeatedly relied on solicited financial support narrated the stigma and shame they experienced. This was felt when they approached their social networks for financial support. In some instances, the support was requested by the participants against their values, if they had options. At face value, these negative undertones are missed, as attention is paid to the resource flows and the actors involved. Family-level social capital played a central role in the provision of care. The onset of sickness revealed an intricacy of positive and negative effects of family-level social capital on the households of participants. Sick members withdrew the role of their labour from productive activities. This initiated a chain reaction of negatives that included delays in the timing of

seasonal activities, reduced production levels and diversity of sources of income. As other family members provided care to the sick, this further reduced the availability of productive labour, compounding the vulnerability of households. A single social capital transaction can carry both positive and negative outcomes, with some being observable while others will not be. Understanding the value of social capital requires to have more depth and openness to unpack the intricacies of preferences and values in transactions.

5.4. RECOMMENDATIONS

5.4.1. Immediate access to social protection for persons testing HIV positive

Social protection programmes are recommended to include immediate access to protective social protection by persons testing HIV positive. This will mitigate the negative impacts on productive activities, income generation and spending. Persons testing HIV positive and enrolling on ART should immediately be referred and eligible to access cash transfers. This will be a measure to reduce expenditure on ineffective healthcare measures, promote adherence treatment, protect and restore household productive labour, secure household assets, and reduce the disruption to productive activities and income-earning and spending. Enrolment into social protection should be part of the referral network of the country's HIV response.

a. Facilitating access to agricultural inputs for persons affected by HIV and AIDS

The country’s social protection programme must include the provision of vouchers to pay for tillage services and agricultural inputs for smallholder farmers who test HIV positive and own land. Access to this support reduces the risk of HIV and AIDS disrupting agricultural production, will allow for the timely preparation of land and access to inputs. This will mitigate the effects of loss of labour and diversion of income due to HIV and AIDS.

b. Providing access to adapted technologies for labour compromised households

Agricultural extension and research services must work with private sector agribusiness and financial services providers to develop and promote technology adapted to the labour and landholding capacity of persons affected by HIV and AIDS. Such technology includes mechanisation, crop intensification practices and access to short maturing and improved crop input varieties.

c. Delivering financial education to HIV and AIDS affected households

Financial education training curriculum must be reviewed to be inclusive of the effects of HIV and AIDS on the preparation and management of household budgets, expenses, debt, savings and setting saving objectives and the household level financial implications of using different sources of healthcare services. Access to such HIV sensitive financial education can improve the financial behaviours of households when they are affected by HIV and AIDS. The financial education curriculum must be delivered through both institutional and community-based service delivery platforms.

5.5. LIMITATIONS OF THE STUDY

Storytelling generates a lot of information, given the open-ended generative questions and the narrations that are shared. In some instances, this led the researcher to collect more information than they could reasonably use. The breadth of understanding of the question was the judgement of the participant. Once a participant started their narration, it was impossible to stop or interrupt them, as long as what they shared was aligning with the question. Any interruption risked sending the wrong signal to the participant. Some might have interpreted that they were providing wrong narrations or providing too much information. This could distract how they responded to subsequent questions. Despite this limitation, the researcher concluded that it was better to collect more than less information. This resulted in the researcher not following-up on issues with any of the participants.

Handwritten notes require high speed hand-writing skills by the researcher. This helps the researcher to keep up with the pace of the oral narration. This also limits the need for regular requests for participants to repeat statements. Often, when participants repeat a statement, they may not reconstruct them the same way and with the same emotion and body language as the first attempt. The researcher had very limited occasions where he asked of participants to repeat statements. The use of a voice recorder is highly recommended to provide two recording methods. The researcher can always playback any parts to make sure that what is handwritten correctly captured the narration.

A limitation emerging after the study is that it did not benefit from the inclusion of observation as part of the research methods. This would, to some extent, have allowed for any changes occurring by the time of the study to be observed. Such changes could relate to the level and

frequency of operation of the economic activities and income spending behaviours. Daily recording of such patterns could have strengthened the findings.

Another limitation of the study is the short time allocated for fieldwork. This did not allow for extended engagement with participants over different seasons. Such an engagement would allow a determination of whether the findings were influenced or dependant on the time or season of the year. The study was conducted in May 2016, which was soon after harvests. At this time, farming households are expected to have sufficient food and income from the sale of crops. This may potentially influence the experience participants narrated on how they generated and spend income. Engaging the same participants at the peak, August to October, of the lean season when food reserves are expected to be at their lowest would potentially influence a different experience. In narratives, the context settings matter as they can influence the lived experiences of participants.

5.6. AREAS FOR FURTHER RESEARCH

Areas of further research emerging from this study are related to income and expenditure analysis for persons affected by HIV and AIDS, and understanding the long-term effects on achievement by children who drop-out and re-enrol in school.

a. *Quantitative and qualitative analysis of income and expenditure losses and gains of persons affected by HIV and AIDS*

Mixed method research is recommended, focusing on both the quantitative and qualitative aspects of income and expenditure losses and gains experienced by persons affected by HIV and AIDS and participating in ISAL. The research could include the analysis of flows of assets in social networks, the differences between the forced sale and market value of assets, changes in quantities of produce, wages, market sales and income and expenditure by persons affected by HIV and AIDS. This might help to better understand how households process and prioritise decisions in the face of changes in the circumstances of their families. Such a study would contribute to a better understanding of the intricacies of both the positive and negative outcomes of social capital. This can add to a better understanding of the extent and rationale of reliance on social capital when positives or negatives are experienced by persons affected by HIV and AIDS. This may also inform when it is most appropriate to time interventions to mitigate the risks of the sickness of the wellbeing of families.

b. *Understanding the long-term effects of school drop-outs in households affected by HIV and AIDS*

Exploratory research is required on the nature and extent of effects of dropping out of school and re-enrolment of children from persons affected by HIV and AIDS. Once persons affected by HIV and AIDS regained the ability to pay for the education needs of their children, they re-enrolled them in school. After that, it is not known if the children required any additional support to overcome the experience of having lived with sick parents and their loss of some educational time. Where children re-enrolled at the same or lower grades, it is not known if schooling with others, of a younger age, had any and what consequences. Some participants narrated how their children were known as beggars and being recurrently sent away from school, for non-payment of fees and levies. This may affect the self-confidence of the children when they re-enrol. Knowledge is required on whether there is any support required for children to recover from the effects of dropping-out. This will include determining how the children perform and their achievements after re-enrolment. This will contribute to understanding whether just getting the children back to school is adequate or complementary support is required and its nature.

5.7. CONCLUSION

The chapter presents conclusions from the study. Conclusions made affirm that sickness negatively affected how persons affected by HV and AIDS generated income. The sequence of change from the onset of sickness included the loss of productive labour in households, which in turn reduced the type and performance level of productivity activities. This reduced the level of income earned and changed the prioritisation of spending on daily needs. Membership to groups and relations that individuals had with family and friends created opportunities for getting financial support, decisions on spending and access to material resources. This affirms the relevance of social capital and collaboration advantage theories. The desire to generate own income, being financially secure and self-sufficient and making spending decisions were important considerations and goals as participants participated in ISAL. The orientations of the participants towards self-help and efficacy aligned with the economic empowerment theory. Recommendations emerging from the study include enabling persons testing HIV positive to access social protection, adapted technology for agriculture to mitigate the effects of sickness on income and labour and HIV and AIDS sensitive financial education. Areas of further research emerging include a quantitative and qualitative analysis of income and expenditure changes for persons affected by HIV and AIDS. There is a need to

understand the scope of effects from dropping-out of school and the adequacy of support mechanisms when children re-enrol in school.

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ANNEXURES

Annexure A: UNISA Department of Health Studies Ethical Clearance

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/511/2016

Date: 3 February 2016 Student No: 4452-948-1

Project Title: Exploring how Internal Saving and Lending (ISAL) services assist households affected by HIV and AIDS to sustain livelihoods: A case of households in a rural area of Zimbabwe.

Researcher: Alfred Hamadziripi

Degree: Research Proposal in Social Behaviour Studies in HIV/AIDS Code: DISSB8K

Supervisor: O Nkosi
Qualification: Masters in Public Health
Joint Supervisor: Mr L Roets

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

FOL **Prof L Roets**
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE
Prof L M Moleki

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure B: Request for permission to conduct research letter

Request for permission to conduct research at Pride HIV AND AIDS Service Organization (BHASO)

Exploring how Internal Saving and Lending (ISAL) services assist households affected by HIV and AIDS and AIDS to sustain livelihoods: A case of households in a rural area of Zimbabwe.

17th March 2016

Mrs. Cathia Dehwe
Programmes Department
6 Rekayi Tangwena Avenue
Masvingo
+263772433591
Pride@bhaso.com

Dear Mrs. Cathia Dehwe,
I, Alfred Hamadziripi am doing research with Oniah Nkosi, a Supervisor in the Department of Sociology towards a MA (Social and behavioural studies in HIV AND AIDS) at the University of South Africa. I am using my own resources to fund the research. We are inviting you to participate in a study entitled *Exploring how Internal Saving and Lending (ISAL) services assist households affected by HIV and AIDS and AIDS to sustain livelihoods: A case of households in a rural area of Zimbabwe.*

The aim of the study is to generate understanding on how ISAL services change the ability of households affected by HIV and AIDS and AIDS to generate income and to sustainably meet their expenditure on daily livelihood needs.

Your Organization has been selected because of the nature of work that you have implemented which aligns with the interest to the study. The study focuses on community members that participated in both ISAL and HIV/AIDS programmes. I kindly request your support in the identification of 3 ISAL groups with HIV/AIDS affected members who have also participated in your HIV/AIDS programmes.

The study will involve 9 ISAL members who will interviewed and while the researcher takes notes and audio tapping. The interview for each member will be in three parts. First I will ask members questions that will help them start sharing their story on when and how they first experienced the effects of HIV/AIDS on their ability to meet day to day livelihoods income and expenditure needs, their joining of ISAL and how being a member of an ISAL group has affected them in dealing with the effects of HIV/AIDS on the circumstances of their households. After they share their stories I will ask them to highlight any achievements and disappointments. While narrating their stories I will be taking notes and audio recording. After they finish I will ask them further questions on any aspects that need more explanation. In the end I will ask each member to evaluate their story highlighting their analysis of learning the experience, how they resolved issues and the differences they see now and, in the future, when dealing with shocks.
Each member will participate in this study for only one (1) day and each interview is expected to last no more than two and half hours.

The benefits of this study are that it will generate better understanding of how households affected by HIV and AIDS and AIDS and participating in ISAL meet their day to day income and expenditure needs and how access to ISAL savings, loans and share-outs change how participating members meet their livelihoods needs.

Potential risks from the study are expected at the level of individuals to be interviewed. As individuals narrate their stories it is possible that they may recall some unpleasant personal and household experiences which may create discomfort and psychological harm to them. These experiences may include the losses they experienced or the difficult times they had to go through. In the event that they experience discomfort or psychological effects they will be asked to stop their narration or will be requested to let the researcher know and they can be excused from continuing to narrate that part of their experience or the interviewing can be concluded. Further I request that BHASO facilitates for the local Community HIV & AIDS Support Agent (CHASA) to be available to provide any psychosocial support that may be required whenever such moments are experienced.
Feedback procedure will entail immediate summary of findings being shared with each participating member, summarizing the understanding of the narratives and allowing for validation and correction. At the end of the field work feedback will be provided to BHASO field staff and local district officials to share highlights of findings.

Yours sincerely

Alfred Hamadziripi
Researcher

Annexure C: Approval of research email exchange with BHASO
Re: BHASO HIV and ISAL study
Yahoo/Inbox

- **alfred hamadziripi** <alfhamadziripi@yahoo.com>

To:cdehwe@bhaso.org

Cc:nkosi@ilo.org,oniah.nkosi1@gmail.com,mhlanga.claudia@gmail.com

Apr 22 ,2016 at 11:11 AM

Dear Carthia

This is a follow-up to my visit to your Masvingo offices on the 13th April and my telephone call with you on the same day. I followed-up my visit and call with another telephone call to Claudio (BHASO's M&E lead person) on the 19th April. Claudio advised me that the he reviewed the documents that I submitted and agrees with the decision for me to proceed with the planned research. If this is correct, I kindly request an email confirmation from BHASO for my own record and to enable me to proceed with plans for the fieldwork. In the same communication can you also kindly connect me with the BHASO Bikita District field person that I can liaise with to plan for the meetings with the ISAL groups. As I indicated, I am planning to travel back to Masvingo on the 5th May 2016 to conduct the fieldwork. I will be following-up this email with a telephone call.

Thank you for all the support you have given so far. Looking forward to hear from you.

Sincerely

Alfred

- **alfred hamadziripi**

Dear Carthia

This is a follow-up to my visit to your Masvingo offices on the 13th April and my telephone call with you on the same day. I followed-up my visit and call with another telephone call to C

Apr 22 , at 201611:15 AM

- **carthia dehwe** <cdehwe@bhaso.org>

To:alfhamadziripi@yahoo.com

Apr 23 ,2016 at 3:04 PM

Dear Alfred

We will be sending you an email confirmation on Monday where we will also copy the Bikita field officer and connect you with her. I will phone her on Monday and inform her of your plans. I am positive BHASO will benefit from your study, as I have full confidence in Claudio who has given his recommendation to BHASO to authorise you to conduct the study.

Best regards

Cathia

Show original message

- **alfred hamadziripi**

Dear Cathia

Thank you so much, I will look forward to your email. Sincerely Alfred Sent from my iPhone

Apr 25 ,2016 at 7:50 AM

- **carthia dehwe** <cdehwe@bhaso.org>

To:alfhamadziripi@yahoo.com

May 18 ,2016 at 11:26 PM

Dear Alfred

As BHASO we have reviewed the documents you submitted to us and we have no problems with you proceeding with the planned research. I am confident that as an organization we will benefit from this research and your study will add value to our programming.
Hence this mail serves to authorize you to conduct the study. I therefore refer you to our Bikita field officer whom you can liaise with and plan your meetings with the ISAL groups. Her name is Lillian

Chemhere and you may contact her on 0773 907 958.

Best regards

Cathia Dehwe

Project Officer-Prison Health

BHASO

7298 Bugwa Street

Masvingo

0772433591

cathiadehwe@yahoo.com

- **alfred hamadziripi**

Dear Oniah FYI Sent from my iPhone Begin forwarded message: From: carthia dehwe <cdehwe@bhaso.org> Date: 18 May 2016 at 11:26:20 PM CAT To: alfred hamadziripi <alfhamadziripi@yahoo.com> Subject: Re: B

May 19 ,2016 at 3:44 AM

- **Nkosi, Oniah**

Thanks Alfred That's great news indeed. Good luck with your data collection Kind Regards Oni

May 19 ,2016 at 10:31 AM

- **alfred hamadziripi**

  Oniah Hi Just to update you that I have competed the planned 9 interviews with 9 (7 women and 2 men) support group members who are also practising the ISAL methodology. These were drawn from 3 support

  May 26 ,2016 at 4:56 AM

- **Nkosi, Oniah** <nkosi@ilo.org>

Annexure D: Letter affirming informed consent to participate in a research

Study Title: Exploring how Internal Saving and Lending (ISAL) services assist households affected by HIV and AIDS and AIDS to sustain livelihoods: A case of households in a rural area of Zimbabwe.

Researcher: Alfred Hamadziripi

Institution: University of South Africa, Department of Sociology

Address: 451 Wendy Street, Waterkloof Glen, Pretoria, 081, South Africa

Contact number: +27828276486 and +263773598436

Email: alfhamadziripi@yahoo.com

PURPOSE OF STUDY

You are kindly requested to voluntarily participate in this study but before you make a decision it is imperative that you have full understanding of why the study is being undertaken and the processes involved. You are kindly requested to carefully read the information that follows as this will help you in making your decision. You are also informed that you can ask the researcher questions to help you understand more about the research.

The purpose of the study is to generate understanding on how Internal Savings and Lending (ISAL) services change the ability of households affected by HIV and AIDS and AIDS to generate income and to sustainably meet their daily livelihood needs. This will be achieved through listening and analysing the personal narratives of members on the effects of HIV and AIDS on how households earn and spend income and in what way participating in savings and loans activities either prevent the negative impacts, change practices to mitigate impact or create new practices that prevent impact. The findings will inform research on other areas to focus on based on the perspectives of members. The study is being undertaken in partial fulfilment of studies that the Principal Investigator is undertaking with UNISA for a Master of Arts (Social and behavioural studies in HIV-AIDS).

STUDY PROCEDURES

You are being informed that the researcher will ask questions on your life experiences from the time that you were affected by HIV and AIDS and AIDS up to now as a member of an ISAL group and in relation to how you earn income and manage household expenditure. The researcher will be taking notes and also recording on tape the conversation to back-up the

notes. The researcher may repeat some statements you will make to make sure that your narrative is accurately captured. At any point during the interview you are requested, before you answer, to ask the researcher to repeat any question that is not clear. At the end of the interview the researcher will give you a chance to ask questions and you will be briefed on the highlights captured on your narrative and you are welcome to add and correct. The research is planned for 5 days and your particular interview will last no more than two and a half hours.

At the end of the field work you and all members of your ISAL group will be invited to a meeting where the researcher will share the highlight findings from the research.

RISKS

You are being informed that the study is not about you or your family members' past or current health status but your personal and household income and expenditure situation. However, there are challenges that may arise as you recall some uncomfortable experiences. When this occurs, you are encouraged to inform the researcher and you have the right not to answer any or the rest of the questions and you can discontinue the interview or ask for the questions to be skipped. Your Community HIV & AIDS Support Agent (CHASA) is aware of the interview and the likely effects and will be readily made available to support you.

BENEFITS

Participation in the research does not offer you any direct material benefits. However, from the discussions you have an opportunity to reflect on what you have overcome and achieved which may motivate your continuous participation and motivation of others. The findings of the research will benefit research by pointing areas that may need further research on targeting HIV and AIDS affected households with the ISAL methodology.

CONFIDENTIALITY

Your name will be recorded but this will be confidential and is done primarily for follow-up that may be necessary after completion of the interview. You are being made aware that the researcher may record your responses and during analysis they realise some information requires to be verified and which necessitate that you are contacted.

You are informed that in your narration you may make powerful statements that the researcher decides to quote as expressed and recognise you as the source. You will first be informed of such statements and for approval to have your name and that of the group acknowledged. You are informed that you can decide on having the statement included but your name not included, and you can decide on the use of a pseudonym.

The notes and recordings of your interview will be kept for 5 years locked in a filing cabinet that is kept at the private residence of the researcher.

COMPENSATION
You are not provided with any form of compensation for participating in the research.

CONTACT INFORMATION
If you have questions pertaining to this study, you can contact the researcher on the details listed above. You also have the contact details for your CHASA who can support you in dealing with uncomfortable experiences arising from the interview. If you have issues you cannot discuss with the researcher, you have the contact numbers of the BHASO field officer and that of the local District Administrator through whom you can raise them.

VOLUNTARY PARTICIPATION
You are being informed that you can participate in this study voluntarily and therefore you have the right to decide to or not to take part. In the event that you decide on participating you are kindly requested to append your signature below on this form and confirm your decision. Although you sign the form you are also informed that you still have the right to quit the interview process at any point without being obliged to give reasons for doing so. Your quitting will not be held against you and will not affect your relationship with the researcher, your ISAL group and BHASO. In the event that you decide on quitting before the interview is completed the researcher will not use any of the information you shared earlier for the purposes of this study.

CONSENT

I _____ having read the contents of this letter do hereby indicate that I fully understood the information provided and have been satisfactorily provided with opportunities to ask questions that were answered. I hereby express my voluntary participation in this research and I am fully aware that I have the right to quit the interview and with no obligation to give my reasons for doing so and without being liable for anything to the researcher. I have been given a copy of the consent form which I will keep for my own purpose.

Signature of ISAL member _____ Date _____

Signature of Principal Investigator _____ Date _____

Annexure E: Letter of requesting permission to conduct research Bikita district

Study Title: Economic vulnerability of HIV/AIDS affected households and participation in internal savings and lending methodology; exploring the sustainability of experiences of members in rural Bikita district in Zimbabwe

Principal Investigator: Alfred Hamadziripi

Institution: University of South Africa, Department of Sociology

Address: 451 Wendy Street, Waterkloof Glen, Pretoria, 081, South Africa

Contact number: +27828276486 and +263773598436 **Email:** alfhamadziripi@yahoo.com

Purpose of study

Your permission is kindly requested to authorise the undertaking of a qualitative research study for academic purposes with members of ISAL groups promoted by BHASO in your district. The research is being undertaken in partial fulfilment of the Principal Investigator's studies with UNISA for a Master of Arts (Social and behavioural studies in HIV-AIDS).

The purpose of the study is to analyse the contribution of ISAL services to the ability of households to manage sustainably the economic vulnerability from the impact of HIV/AIDS and what members find as core success and worthiness factors of their groups. This will be achieved through listening and analysing the personal narratives of members of groups and their views on how they have been able to either prevent the negative impacts, change practices to mitigate impact or create new practices that prevent impact. The findings will inform any adaptations needed to the ISAL methodology and how research can be more inclusive of issues central to its success from the perspective of members.

Study procedures

The study will involve 30 members of ISAL to be drawn from 5 different groups. These 30 members will be voluntarily interviewed in groups of 3 per session. During the interviews the researcher will ask the ISAL members questions on their life experiences before ISAL and what they now experience in ISAL and their livelihoods. Each member will be given an opportunity to respond to the questions. The responses of members will be recorded as handwritten notes and additionally the interviews will be recorded on tape as back-up to the notes. At the end of each interview ISAL members will be allowed to ask questions that will be

responded to. The research is planned for implementation over 5 days after which you will be provided with debriefing on the highlights of the findings.

Risks

The study will not ask questions about the ISAL members' past or present health but their personal and household economic situation and challenges which may result in them recalling some uncomfortable experiences. When this occurs, the researcher is expected to be observant, encourage the member to speak out if they need to break and remind them of their right not to answer any or the rest of the questions and even discontinue the interview or ask for the questions to be skipped. The BHASO supported Community HIV & AIDS Support Agents will be made aware of the interview and the likely effects and will be requested to be readily available to support any affected member in dealing with the effects of uncomfortable experiences they may have recalled.

Benefits

Participation in the research does not offer any direct material benefits to the respondents who are expected to participate voluntarily. However, from the discussions some members will reflect on what you have achieved since joining ISAL which may motivate them in their continuous participation and encourage others to join. The results to be generated by the research will benefit other similar ISAL programmes that plan or are already working with HIV/AIDS affected households but may not have the same experience as yours and will benefit research by pointing areas with little or no knowledge

Please find accompanying this request the *Letter affirming informed consent to participate in a research* that each sampled ISAL member will be expected to read and sign if they agree to participate.

Looking forward to your favourable consideration of my request

Yours Sincerely

Alfred Hamadziripi

Annexure F: Interview guide (Story telling generative questions)

Changes caused by HIV and AIDS to how household generated and spend income

1. How did HIV and AIDS change the way your household generated income?
2. What way did HIV and AIDS change the way your household spend its income?

Changes ISAL caused to how household generated and spend income

1. How did access to ISAL financial services change the way your household generated income?
2. How did access to ISAL financial services change the way your household spend its income?